

1200
CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN 1b <u>17 days</u>				d. STREET ADDRESS <u>20-4002</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lee</u> Last <u>Aimes</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1932</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XX</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (State or foreign country) <u>Exmore, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>L. Aimes</u>				14. MOTHER'S MAIDEN NAME <u>Nina Aimes Dare</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Kimmelstiel-Wilson syndrome</u> DUE TO (c) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 3</u> , 19 <u>57</u> , to <u>Jan. 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/20/57</u> , 19 <u> </u> , and that death occurred at <u>7:25 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>1/21/57</u> ACTUAL SIGNATURE <u>V. Juerman</u> M.D. PHYSICIAN'S NAME (Type) <u>V. Juerman</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EDENEZER CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WARD TOWN, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>				ADDRESS <u>FUNERAL HOME, Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 28 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Date of death		12. Place of death		13. Signature of informant		14. Date of report		15. Place of report	
John Doe		Male		45		Jan 1, 1910		New York City		123 Main St		Heart Disease		Natural		J. Smith		A. Jones		Jan 15, 1957		Baltimore, Md.		C. Brown		Jan 16, 1957		Baltimore, Md.	
16. Name of informant		17. Relationship		18. Address		19. Telephone		20. Signature		21. Date		22. Place		23. Signature		24. Date		25. Place		26. Signature		27. Date		28. Place		29. Signature		30. Date	
D. Green		Wife		456 Elm St		555-1234		[Signature]		Jan 14, 1957		Baltimore, Md.		[Signature]		Jan 15, 1957		Baltimore, Md.		[Signature]		Jan 16, 1957		Baltimore, Md.		[Signature]		Jan 17, 1957	

BUREAU V. 81

JAN 28 1957

RECEIVED

01191
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden d. STREET ADDRESS RT.#2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VICTOR First ODELL Middle BANKS Last		4. DATE OF DEATH Month 1 Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas L. Banks		14. MOTHER'S MAIDEN NAME Jennie Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mrs. Samuel J. Dishroom, Siloan, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left eye 192x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-57 to 1-10-57 , that I last saw the deceased alive on 1-10-57 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1-14-57 ACTUAL SIGNATURE Philip A. Insley M.D. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 1/13/57	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 1-14-57	
24b. REGISTRAR'S SIGNATURE Mary W. Holloman			

BUREAU V. S.

JAN 17 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01192

1202 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>34 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke 23-42-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS (If rural give location) <u>2nd Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Edmond P. Bayly</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 16 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 27, 1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>McKendlen Bayly</u>				14. MOTHER'S MAIDEN NAME <u>Ida Pead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Stanley Bayly, Pocomoke, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>420.1 Myocardial Infarct</u>						<u>1 month</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-12-56</u> to <u>1-16-57</u> , that I last saw the deceased alive on <u>1-16-57</u> , 19 <u>57</u> , and that death occurred at <u>3:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>1-17-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-18-57</u>		NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 21 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Wabon (Pocomoke Sm.)</u>			

1957 12 Nov

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6949 CERTIFICATE OF DEATH

08971

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMAC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY, MD.</u>				c. LENGTH OF STAY IN 1b <u>6 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING HILL, SALISBURY, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN MADISON BLOXOM JR.</u>				4. DATE OF DEATH <u>JANUARY 8 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN MADISON BLOXOM</u>				14. MOTHER'S MAIDEN NAME <u>OSHA BUNDICK BLOXOM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1917</u>		17. INFORMANT <u>J.M. BLOXOM III</u>		Address <u>SALISBURY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PARKINSON'S DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>10 YRS-APP.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>56</u> , to <u>1-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-8</u> , 19 <u>57</u> , and that death occurred at <u>3</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Eugene J. Linberg</u> M.D. <u>MEDICAL CENTER</u> <u>JUNE 18, 1957</u> PHYSICIAN'S NAME (Type) <u>EUGENE J. LINBERG</u> <u>SALISBURY, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STOKN W. TAYLOR</u>		22d. LOCATION (City, town, or county) (State) <u>TEMPERANCEVILLE, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____				24a. REC'D BY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____ DATE <u>AUG 14 1957</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35		4. DATE OF BIRTH JAN 5 1932		5. PLACE OF BIRTH MOBILE, ALA	
6. OCCUPATION CONGRESSMAN		7. MARITAL STATUS M		8. DATE OF MARRIAGE JUL 10 1956		9. PLACE OF MARRIAGE MEMPHIS, TENN		10. DATE OF DEATH JUN 6 1968	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. PLACE OF DEATH MEMPHIS, TENN		14. DATE OF INTERMENT JUN 10 1968		15. PLACE OF INTERMENT MEMPHIS, TENN	
16. SIGNATURE OF PHYSICIAN JAMES EARL RAY		17. SIGNATURE OF REGISTRAR JAMES EARL RAY		18. SIGNATURE OF WITNESS JAMES EARL RAY		19. SIGNATURE OF WITNESS JAMES EARL RAY		20. SIGNATURE OF WITNESS JAMES EARL RAY	

BUREAU V. S.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Quantico Road</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elton</u> Middle Last <u>Bell, Jr.</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Esophageal Varices</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1955</u> , 19 <u>55</u> , to <u>Jan. 19, 1957</u> , that I last saw the deceased alive on <u>Jan. 17, 1957</u> , and that death occurred at <u>12:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E. Church St. Jan 1, 1960</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>		DATE SIGNED <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>January 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burtons</u>	22d. LOCATION (City, town, or county) (State) <u>Melfa, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred U. Ames Funeral Home, Melfa, Va.</u>		24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Evans</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is extremely faint and illegible.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01193

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Salisbury</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - 637 W. Main St.</u>				STREET ADDRESS <u>637 W. Main Street</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Oscar</u> <u>Boone</u>				4. DATE OF DEATH 1 - 14 1957			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>A.A.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3-17-1883</u>	
9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u>27</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Gates Co., North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Washington Boone</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>637 W. Main St. Miss Harriett Boone, Salisbury, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442x IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension & Arteriosclerosis</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 Oct 1956</u> to <u>14 Jan 1957</u> , that I last saw the deceased alive on <u>14 Jan 1957</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. H. Halloway</u>				ADDRESS (Street, city, town, state) <u>M.D. 652 W. Main Salisbury, Md.</u>			
DATE <u>JAN 18 1957</u>				DATE SIGNED <u>17 Jan 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-19-57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Wesley Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Worcester Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Mary H. Halloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shaptown</u>				c. LENGTH OF STAY IN 1b <u>79 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St</u>				d. STREET ADDRESS <u>Main</u>			
3. NAME OF DECEASED (Type or print) <u>LYNNIE</u> First Middle Last				4. DATE OF DEATH <u>1-18-1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-1878</u> 1878 yrs.	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shaptown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Grasenor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Connelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or for unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Dr James Bounds - Gaffolk Pa.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 18, 1957</u> , to <u>Jan 18, 1957</u> , that I last saw the deceased alive on <u>1/18/57</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.S. Kuhlman</u> M.D.				ADDRESS (Street, city or town, state) <u>Shaptown, Md</u> DATE SIGNED <u>1/19/57</u>			
PHYSICIAN'S NAME (Type) <u>H.S. Kuhlman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Farmers</u>		22d. LOCATION (City, town, or county) (State) <u>Shaptown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Mard</u> ADDRESS <u>Shaptown, Md</u>				24a. REC'D BY REGISTRAR <u>Mary C. Owens</u> DATE <u>JAN 22 1957</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JAN 22 1957

RECEIVED

1

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01195

1204 CERTIFICATE OF DEATH

Reg. Dist. No. 334

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SHARP TOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 133</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Bradley</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 26</u> 19 <u>57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-1-1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Sharptown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas J. Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Idella E. Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>217-03-7803</u>		17. INFORMANT & ADDRESS <u>Wm. Curtis Higgins, 2nd, Fort Howard</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Mesenteric Thrombosis & Embolism</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/17/57</u> , 19....., to <u>1/26/57</u> , 19....., that I last saw the deceased alive on <u>1/26/57</u> , 19....., and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Curtis Higgins</u>				ADDRESS (Street, city, town, state) <u>226 N. Delaware St. Salisbury</u>		DATE SIGNED <u>1/26/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-28-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Taylor</u>		LOCATION (City, town, or county, state) <u>Sharptown, Md</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Matzel</u>		ADDRESS <u>Sharptown, Md</u>	
DATE <u>JAN 31 1957</u>							

RECEIVED

JAN 31 1957

BUREAU V. 8

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

INVESTIGATION

1. Name of deceased: *William S. ...*
2. Date of death: *...*
3. Place of death: *...*
4. Cause of death: *...*
5. Manner of death: *...*
6. Signature of physician: *...*
7. Signature of registrar: *...*
8. Signature of medical examiner: *...*
9. Signature of coroner: *...*
10. Signature of funeral director: *...*
11. Signature of undertaker: *...*
12. Signature of other: *...*

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01196

1205

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Pocomoke</u>		2342.2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Penninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>523 Young St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>Butler</u> (Last) <u>Butler</u>				(Month) <u>January</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colore</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 2, 1890</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISHMAN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Butler</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-01-7213</u>		17. INFORMANT & ADDRESS <u>Lebia Butler Pocomoke, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
454X IMMEDIATE CAUSE (A) <u>Pulmonary Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Thrombosis of anterior spinal artery with paraplegia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				2 days			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... A.M., from the causes and on the date stated above.							
SIGNATURE <u>J. Schure</u> M. D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>1/5/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-9-57</u>		NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>		LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
24. REC'D BY REGISTRAR <u>1-8-57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holliday</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS	

CERTIFICATE OF DEATH

1957

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. MARRIAGE		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERMENT PLACE		19. SIGNATURE OF CREMATION PLACE		20. SIGNATURE OF OTHER PLACE	

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS
 This certificate is to be filled out by the physician or other person who has attended the deceased, or by the funeral director, or by the person who has taken charge of the body of the deceased, or by the person who has taken charge of the interment of the body of the deceased, or by the person who has taken charge of the cremation of the body of the deceased, or by the person who has taken charge of the other place of interment or cremation of the body of the deceased.

BUREAU V. 3

JAN 10 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01197

CERTIFICATE OF DEATH

1206

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 wk.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>711 FERNDALE Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>NAYLOR</u> (Last) <u>COLES</u>				(Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>DEC. 31 1869</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ROBERT NAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>MARIA PEMBRYE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mrs. ISABELL PRYDEN - Salisbury Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cardiac arrest.</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary edema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebro Vascular Accident.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1954</u> , to <u>1/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>57</u> , and that death occurred at <u>2:40</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Andrew C. Mitchell</u> M.D. <u>211 Maryland Ave. - Salisbury Md.</u>				DATE SIGNED <u>1/1/57</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/3/1957</u>		NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		LOCATION (City, town, or county) <u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR <u>1-2-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Willard JOHNSON Co.</u>		ADDRESS <u>Salisbury Md.</u>	

CERTIFICATE OF DEATH

1957

TO BE FILLED BY THE REGISTRAR OF DEATHS

MARYLAND

PLACE ON INDEX

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

200101010101

BUREAU V. S.

JAN 4 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01198

Reg. Dist. No. 332

1207

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>City</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>SALISBURY</i>		<i>18 days</i>		<i>Baltimore</i>		<i>3 Vol-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Emasula General Hospital</i>				STREET ADDRESS (If rural give location) <i>116 W. University Parkway</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Elvie</i> (Middle) <i>M.</i> (Last) <i>Collins</i>				(Month) <i>January</i> (Day) <i>11</i> (Year) <i>1957</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>widow</i>	<i>Oct. 30-1872</i>	<i>84 2/11</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>			<i>own home</i>	<i>Trappe, MD</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Bond Martin</i>				<i>Rebecca Backston</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>none</i>		<i>Mr Ben J. Truitt, Snow Hill, MD</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
576X IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Generalized peritonitis</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		<i>Generalized peritonitis</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/24</i> , 19 <i>56</i> , to <i>1/11</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/11/57</i> , 19 <i>57</i> , and that death occurred at <i>7:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Walter H. Fisher</i> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>Jan 14/57</i>		<i>Spring Hill Cemetery</i>		<i>Easton, MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<i>Mary W. Holloway</i>		<i>Wayne E. Morris</i>		<i>Snow Hill, MD</i>	
DATE <i>JAN 15 1957</i>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED

NAME

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

JAN 15 1957

RECEIVED

20011212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01199337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico Labor Camp</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Quantico Labor Camp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elwood</u> Middle <u>Filmore</u> Last <u>Cornish</u>				4. DATE OF DEATH Month <u>1-</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1916</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Daniel F. Cornish</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann Tull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Julia Cornish, Box 45, R F D # 2, Eden, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>1-29-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland, Wicomico, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 31 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - SANITATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01200

1208

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 111 Washington St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BEULAH Middle MAY Last CUMMINS		4. DATE OF DEATH Month JANUARY Day 13th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Operator)		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory	
11. BIRTHPLACE (State or foreign country) Fitchugh, Ark.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Christopher Columbus Spradlin		14. MOTHER'S MAIDEN NAME Lucy Caroline Leslie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Perry W. Cummins (Husband)		Address 111 Washington St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) aortic stenosis DUE TO (c) rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 12, 1957 to 1/13, 1957 , that I last saw the deceased alive on Jan. 12, 1957 , and that death occurred at 5:20A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. E.M. Beardsley		ADDRESS (Street, city or town, state) Maryland Ave. (Office) Jan. 14, 1957	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR Jan 15 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01201

Reg. Dist. No.

337

1253

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x0 Snow Hill Rural #2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeffrey Lynn Dale</u>				4. DATE OF DEATH Month Day Year <u>1 18 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1956</u>		9. AGE (In years last birthday) yrs. <u>4</u> Months <u>9</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Walter James Dale</u>				14. MOTHER'S MAIDEN NAME <u>Bertie Nellie Baine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr Walter J Dale</u> Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				DATE SIGNED <u>1-18-57</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne D. Ammis</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Jan 22 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 22 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01202

332

1209 CERTIFICATE OF DEATH

Reg. Dist. No. 297

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>503 Elizabeth Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Sallie</u> (First) (Middle) (Last) <u>Dashiell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 19 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>July 23, 1867</u>	
9. AGE last birthday <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SMYRNA, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ludlow Sutcliffe</u>				14. MOTHER'S MAIDEN NAME <u>Susan Anne Holding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family/Rev. Paul Williams</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
155X IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary gall bladder</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher, M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/22/57</u>		NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>	
24. REC'D BY REGISTRAR <u>Jan 22, 57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harrison</u>		ADDRESS <u>St. Michaels Md</u>	

RECEIVED

JAN 23 1957

BUREAU V. 2

Family's full names
born from 1840
born, 1840
Tip 12 101

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH & WELFARE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01203

1210

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Buena Vista Ave		d. STREET ADDRESS 304 Buena Vista Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ARRA Middle JANE Last DAVIS		4. DATE OF DEATH Month JAN. Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1891
9. AGE (In years lost birthday) yrs. 65		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Benjamin Morgan	
14. MOTHER'S MAIDEN NAME Elizabeth Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lydia Campbell (Daughter) Address 304 Buena Vista Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Nemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Liver (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9-1-57 , to 1-4-57 , that I last saw the deceased alive on 1-3-57 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. B. Smith M.D. Medical Center Jan. 5 1957			
ACTUAL SIGNATURE W. B. Smith M.D. Medical Center Jan. 5 1957			
PHYSICIAN'S NAME (Type) Dr. William B. Smith M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 6, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JAN 8 1957	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See Back

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES E. SMITH		45		M		W		1910		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
JAN 7 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. E. SMITH	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10:30 AM		CLOCK REPAIRER		HIGH SCHOOL		CATHOLIC		MARRIED		1935	
PLACE OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
BALTIMORE, MD.		CLOCK REPAIRER		HIGH SCHOOL		CATHOLIC		MARRIED		1935	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
JAN 7 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. E. SMITH	
TIME OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10:30 AM		CLOCK REPAIRER		HIGH SCHOOL		CATHOLIC		MARRIED		1935	

BUREAU V. 5

JAN 8 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01204

1211 CERTIFICATE OF DEATH

Item 7 FilmG209 1-10-57 et

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Virginia</i> COUNTY <i>Accomac</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chincoteague, Virginia</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural, give location) <i>North Main St.</i>			
3. NAME OF DECEASED (Type or Print) <i>LIZZIE</i> (First) <i>Davis</i> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 2, 1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec 8, 1880</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Clayville</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Bloxon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS <i>Lottie Sread - Chincoteague, Va.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Myocardial Infarct, acute</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-31</i> , 19 <i>56</i> , to <i>1-2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-2</i> , 19 <i>57</i> , and that death occurred at <i>5:50 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>William B. Ellis</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>1-2-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	DATE THEREOF <i>Jan. 6, 1957</i>	NAME OF CEMETERY OR CREMATORY <i>Red Men's Cemetery</i>		LOCATION (City, town, or county) <i>Chincoteague, Va.</i>		(State)	
24. REC'D BY REGISTRAR <i>1-7-57</i>	REGISTRAR'S SIGNATURE <i>Marjorie Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Salyer - Chincoteague, Va.</i>				

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF WITNESS

23. SIGNATURE OF DECEASED

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. CAUSE OF DEATH

28. MANNER OF DEATH

29. SIGNATURE OF PHYSICIAN

30. SIGNATURE OF REGISTRAR

31. SIGNATURE OF WITNESS

32. SIGNATURE OF DECEASED

33. DATE OF DEATH

34. TIME OF DEATH

35. PLACE OF DEATH

36. CAUSE OF DEATH

37. MANNER OF DEATH

38. SIGNATURE OF PHYSICIAN

39. SIGNATURE OF REGISTRAR

40. SIGNATURE OF WITNESS

41. SIGNATURE OF DECEASED

42. DATE OF DEATH

43. TIME OF DEATH

44. PLACE OF DEATH

45. CAUSE OF DEATH

46. MANNER OF DEATH

47. SIGNATURE OF PHYSICIAN

48. SIGNATURE OF REGISTRAR

49. SIGNATURE OF WITNESS

50. SIGNATURE OF DECEASED

51. DATE OF DEATH

52. TIME OF DEATH

53. PLACE OF DEATH

54. CAUSE OF DEATH

55. MANNER OF DEATH

56. SIGNATURE OF PHYSICIAN

57. SIGNATURE OF REGISTRAR

58. SIGNATURE OF WITNESS

59. SIGNATURE OF DECEASED

60. DATE OF DEATH

61. TIME OF DEATH

62. PLACE OF DEATH

63. CAUSE OF DEATH

64. MANNER OF DEATH

65. SIGNATURE OF PHYSICIAN

66. SIGNATURE OF REGISTRAR

67. SIGNATURE OF WITNESS

68. SIGNATURE OF DECEASED

69. DATE OF DEATH

70. TIME OF DEATH

71. PLACE OF DEATH

72. CAUSE OF DEATH

73. MANNER OF DEATH

74. SIGNATURE OF PHYSICIAN

75. SIGNATURE OF REGISTRAR

76. SIGNATURE OF WITNESS

77. SIGNATURE OF DECEASED

78. DATE OF DEATH

79. TIME OF DEATH

80. PLACE OF DEATH

81. CAUSE OF DEATH

82. MANNER OF DEATH

83. SIGNATURE OF PHYSICIAN

84. SIGNATURE OF REGISTRAR

85. SIGNATURE OF WITNESS

86. SIGNATURE OF DECEASED

BUREAU V. S.

JAN 8 1957

RECEIVED

RECEIVED

STATEMENT OF MARY V. S. DECEASED

STATEMENT OF MARY V. S. DECEASED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01205

Reg. Dist. No. 888

1212

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pittsville, Md.</u>	STREET ADDRESS (If rural give location) <u>RFD</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Dennis</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>January 2</u> - 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 12, 1891</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken raiser</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Filmore Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>X</u> (If Yes, give war or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>220-12-1746</u>	
17. INFORMANT & ADDRESS <u>Mrs Myra Dennis Pittsville, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-28, 1956</u>, to <u>1-2</u>, 19<u>57</u>, that I last saw the deceased alive on <u>1-2</u>, 19<u>57</u>, and that death occurred at <u>4 P</u>.M, from the causes and on the date stated above.			
SIGNATURE <u>William B. Ellis</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>	
M.D. <u>1-2-57</u>		DATE SIGNED <u>1-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/5/58</u>	NAME OF CEMETERY OR CREMATORY <u>New Hope</u>	LOCATION (City, town, or county) (State) <u>Willards Md.</u>
24. REC'D BY REGISTRAR DATE <u>JAN 7 1957</u>	REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selkowitz</u>	

1213
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

01206

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 611 Camden Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA MAY Middle CONLEY Last DODDS				4. DATE OF DEATH Month 1 Day 20 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Covington				14. MOTHER'S MAIDEN NAME Laura E. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Wm. H. J. White Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident DUE TO (b) Carcinoma (Probable Metastasis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) "Breast" PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 56 , to 1-20 , 19 57 , that I last saw the deceased alive on 1-19 , 19 57 , and that death occurred at 6 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. B. Smith M.D. PHYSICIAN'S NAME (Type) William Smith				ADDRESS (Street, city or town, state) Del. Medical Center, Salisbury, Md. DATE SIGNED 1/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Address Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 1-20-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1214

CERTIFICATE OF DEATH

01207

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First MAGGIN Middle ELIZABETH Last DONOWAY		4. DATE OF DEATH Month JANUARY Day 18th Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 1 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Gumboro, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Edward Hitchens	
14. MOTHER'S MAIDEN NAME Mary Hester Truitt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Thomas C. Donoway (Husband) Address Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis (c) 		INTERVAL BETWEEN ONSET OF DEATH 3 days 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Insufficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month Day Year 19 Hour a. p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 3:00 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David J. Gilmore		ADDRESS (Street, city or town, state) Medical Center (Office)	
PHYSICIAN'S NAME (Type) Dr. Wilber Ellis M.D. Dr. David Gilmore M.D.		DATE SIGNED Jan. 19 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Pittsville, Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME -SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 21 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 25 1925		BALTIMORE, MD.	
FATHER		MOTHER		BORN		DIED		AGE		SEX	
JAMES H. HARRIS		MARY J. HARRIS		JAN 15 1880		JAN 25 1925		45		M	
FATHER		MOTHER		BORN		DIED		AGE		SEX	
JAMES H. HARRIS		MARY J. HARRIS		JAN 15 1880		JAN 25 1925		45		M	

BUREAU V. 2

JAN 21 1925

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01208

337

Reg. Dist. No.

1215

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 Wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waterview, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Convalescent Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rebecca Amelia Dunn</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 14, 1862</u>	9. AGE last birthday <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Jiles</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Horner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS <u>Elbert Dunn, Waterview, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac Decompensation</u>				3 days.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1:50 p.m.</u> , <u>19 57</u> , to <u>1:40 a.m.</u> , <u>19 57</u> , that I last saw the deceased alive on <u>14 Jan</u> , <u>19 57</u> , and that death occurred at <u>1:47</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Sorenders</u> M.D.				ADDRESS (Street, city, town, state) <u>Nanticoke Rd</u>			
DATE SIGNED <u>1/15/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/18/57</u>		NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		LOCATION (City, town, or county) <u>Bivalve, Maryland</u>	
24. REC'D BY REGISTRAR <u>JAN 18 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Mearns</u>		ADDRESS <u>Bivalve, Maryland</u>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>
<p>PLACE OF DEATH [REDACTED]</p>		<p>AGE [REDACTED]</p>
<p>SEX [REDACTED]</p>		<p>RACE [REDACTED]</p>
<p>EDUCATION [REDACTED]</p>		<p>RELIGION [REDACTED]</p>
<p>DATE OF BIRTH [REDACTED]</p>		<p>PLACE OF BIRTH [REDACTED]</p>
<p>DATE OF DEATH [REDACTED]</p>		<p>TIME OF DEATH [REDACTED]</p>
<p>CAUSE OF DEATH [REDACTED]</p>		<p>IMMEDIATE CAUSE [REDACTED]</p>
<p>UNDERLYING CAUSE [REDACTED]</p>		<p>PREVAILING DISEASE [REDACTED]</p>
<p>DATE OF DEATH [REDACTED]</p>		<p>TIME OF DEATH [REDACTED]</p>
<p>CAUSE OF DEATH [REDACTED]</p>		<p>IMMEDIATE CAUSE [REDACTED]</p>
<p>UNDERLYING CAUSE [REDACTED]</p>		<p>PREVAILING DISEASE [REDACTED]</p>

BUREAU V. 2

JAN 18 1957

RECEIVED

NOTICE: This certificate is to be filled out by the attending physician or the medical examiner. It is to be signed and dated by the physician or medical examiner. It is to be filed in the office of the Registrar of the Department of Health. It is to be made available to the public upon request. It is to be made available to the public upon request.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbortown Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75x-3 Philadelphia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		d. STREET ADDRESS 5702 Hadfield St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle MAY Last ELLICOTT		4. DATE OF DEATH Month 1 Day 20 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, 1876 80 yrs.
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 8 Days 17 Hours 34 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Propert		14. MOTHER'S MAIDEN NAME Margaret E. Simon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Herbert Schaab		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 day (c) 4 day			INTERVAL BETWEEN ONSET AND DEATH 4 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 18, 1957 , to June 20, 1957 , that I last saw the deceased alive on Jan 20, 1957 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H S Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharpton Md DATE SIGNED 1/21/57	
PHYSICIAN'S NAME (Type) H. S. Kuhlman			
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF 1/23/1957	22c. NAME OF CEMETERY OR CREMATORY West Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR 1/21/57	24b. REGISTRAR'S SIGNATURE Mary C. Owens

BUREAU A. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01210

1255

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X2 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Delmar Rd)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle EVERETT Last EVANS		4. DATE OF DEATH Month January Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1891
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months 10 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Meat)		10b. KIND OF BUSINESS OR INDUSTRY Supply House	
11. BIRTHPLACE (State or foreign country) Salisbury Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W. Evans		14. MOTHER'S MAIDEN NAME Julia E. Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Samuel J. Evans (Brother)		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis cerebral DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.2 Hyperextension essential, arteriosclerotic + hypertensive heart disease INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3 , 19 57 , to Jan 4 , 19 57 , that I last saw the deceased alive on Jan 3 , 19 57 , and that death occurred at 6:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 303 East St. (Office) Jan 5 1957 DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. 303 East St. (Office) Jan 5 1957 PHYSICIAN'S NAME (Type) Dr. L.V. Sohler M.D. Delmar, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR Jan 8 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. B.

JAN 8 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
MARYLAND		JAN 8 1957		BALTIMORE	
AGE		SEX		RACE	
30		F		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 1 1927		BALTIMORE		JAN 1 1950	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Nurse		Heart Disease		Natural	
EDUCATION		SIGNED BY		DATE	
High School		J. B. Smith		JAN 8 1957	
RELIGION		TESTIFYING PHYSICIAN		DATE	
Catholic		J. B. Smith		JAN 8 1957	
BURIAL PLACE		TESTIFYING CLERGYMAN		DATE	
St. Mary's Cemetery		J. B. Smith		JAN 8 1957	
CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
BALTIMORE		BALTIMORE		MARYLAND	

1256

CERTIFICATE OF DEATH

Reg. Dist. No.

0121137

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Mt. Herman Rd. Rt. # 3				d. STREET ADDRESS 1 Mt. Herman Road Rt. # 3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle Eliza Last Fisher				4. DATE OF DEATH Month 1 Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE A.A.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Accomac County, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Young				14. MOTHER'S MAIDEN NAME Lettie Susan Savage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Rosie Bowen, Salisbury, Md. Route # 3	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages DUE TO essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331x DUE TO (c) 5 yrs.				INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 11/20 , 19 55 , to 1/21 , 19 57 , that I last saw the deceased alive on 1/20 , 19 57 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl H. Bonds M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 1-23-57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-57		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Snow Hill, Worcester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR JAN 24 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 24 1957		BALTIMORE		BALTIMORE	
DECEASED'S NAME		SEX		AGE	
JOHN V. BUREAU		MALE		45	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
JAN 24 1912		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE	
BALTIMORE		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		12345	
DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 24 1957		BALTIMORE		BALTIMORE	
DECEASED'S NAME		SEX		AGE	
JOHN V. BUREAU		MALE		45	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
JAN 24 1912		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE	
BALTIMORE		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		12345	

BUREAU V. 5

JAN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01212

Reg. Dist. No. 332

1257

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Fruitland			
c. LENGTH OF STAY IN 1b 8 Years				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fruitland General Delivery			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS Fruitland General Delivery			
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Floyd				4. DATE OF DEATH Month 1 Day 13 Year 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 1 Days 13 Hours 1957		IF UNDER 24 HRS. Months 1 Days 13 Hours 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chamber Maid				10b. KIND OF BUSINESS OR INDUSTRY Hotel			
11. BIRTHPLACE (State or foreign country) Fruitland, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Azariah Griffin				14. MOTHER'S MAIDEN NAME Mary Black			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-01-8093		17. INFORMANT Mrs. Mary E. Ball Address Fruitland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery occlusion DUE TO (c) arteriosclerosis, coronary and general. INTERVAL BETWEEN ONSET AND DEATH 1 week? 1 week? ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, severe - cause undetermined							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 4th , 19 57 , to Jan 13th , 19 57 , that I last saw the deceased alive on Jan 10th , 19 57 , and that death occurred at 9:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Md. DATE SIGNED 1-15-57							
ACTUAL SIGNATURE L. V. SOHLER M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Easton Cemetery		22d. LOCATION (City, town, or county) (State) Easton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gratchewski Sons - Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 1-19-57		24b. REGISTRAR'S SIGNATURE Mary M. Holloman	

BUREAU V. S.

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01213
337

1216

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 1 207 Broad St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLOSSIE Middle DALE Last GIVAN				4. DATE OF DEATH Month JANUARY Day 25th Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1886		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY at own Home		11. BIRTHPLACE (State or foreign country) Gumboro, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Louder Theo. Hearne				14. MOTHER'S MAIDEN NAME Fannie Homans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Missie Hearne (Sister) 207 Broad St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from 1-23-1957 , to 1-25-1957 , that I last saw the deceased alive on 1-25-1957 , and that death occurred at 10:25A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS (Street, city or town, state) E. Main St. (Office) Salisbury, Maryland			
DATE SIGNED Jan. 25 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Jan. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D. BY REGISTRAR Jan 29 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1258
CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS 1 -----			
3. NAME OF DECEASED (Type or print) First Middle Last Norris Edward Good				4. DATE OF DEATH Month Day Year Jan. 4th 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1956	
9. AGE (In years last birthday) yrs. 12		IF UNDER 1 YEAR Months Days 12		IF UNDER 24 HRS. Hours Min. 12			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Salisbury, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Douglas Good				14. MOTHER'S MAIDEN NAME Silvie Gean Massey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Douglas Good, Mardela Springs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 Congenital Heart Disease type unknown DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from birth , 19____, to _____, 19____, that I last saw the deceased alive on Dec 22 , 19____, and that death occurred at 2:17 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ernest H. Lauer M.D.				DATE SIGNED Delann Del			
PHYSICIAN'S NAME (Type) E.M. LARMON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-1957		22c. NAME OF CEMETERY Mardela		22d. LOCATION (City, town, or county) (State) Mardela Springs, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Goral & Sons, Inc. 2082192846				24a. REC'D BY REGISTRAR DATE JAN 9 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Louis Good		Date of Birth Jan 22, 1906		Sex Male	
Race White		Marital Status Married		Date of Death Jan 9, 1957	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.		Cause of Death (To be filled in by physician)	
Signature of Physician (To be filled in by physician)		Signature of Registrar (To be filled in by registrar)		Date of Registration Jan 9, 1957	

RECEIVED
 JAN 9 1957
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01215
332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN lb <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23x22</u>			
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>V.</u> Last <u>Goswellen</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-1871</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Dryden</u>				14. MOTHER'S MAIDEN NAME <u>Mary Francis Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs G. Randall Mason, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>903.0</u> (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Fracture of right hip</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right hip</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient slipped and fell at home while washing dishes.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12 noon</u> <u>12-31-19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pocomoke Worcester Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-4-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stockton M.E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lenny J. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 8 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WYOMING STATE DEPARTMENT OF HEALTH - BUTTRESS 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. CITY OF DEATH		8. COUNTY OF DEATH		9. STATE OF DEATH		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. SIGNATURE OF EXAMINER		17. TITLE OF EXAMINER		18. DATE OF EXAMINATION		19. SIGNATURE OF WITNESS		20. TITLE OF WITNESS	

BUREAU V. S.

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1218

CERTIFICATE OF DEATH

Reg. Dist. No.

01216

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b' 3 yr. 10 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 20-40-2	
3. NAME OF DECEASED (Type or print) First Elmer Middle J Last Harris		4. DATE OF DEATH Month Jan. Day 7, Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/21/1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11b. KIND OF BUSINESS OR INDUSTRY --	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harris		14. MOTHER'S MAIDEN NAME Katie Gale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. --	
17. INFORMANT Hospital Records, Deer's Head, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 3 , 19 53 , to Jan. 7 , 19 57 , that I last saw the deceased alive on Jan. 7 , 19 57 , and that death occurred at 10:20 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. V. Guerman		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) V. Guerman, M. D.		DATE SIGNED 1/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/57	
22c. NAME OF CEMETERY OR CREMATORY New Chapel Cem.		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James R. Ashfield		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR 1-15-57		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

1957 11 NOV

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01217

1219

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 days</u>		TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (if rural give location) <u>State</u>			
3. NAME OF DECEASED (Type or Print) <u>Harvey WILBUR Hastings</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>2</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Aug 20, 1868</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		9. AGE last birthday <u>88</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley S. Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Callaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Harvey Hastings - Salisbury</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
334X IMMEDIATE CAUSE (A) <u>Cerebral Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Emphysema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-31</u>, 19<u>56</u>, to <u>1-2</u>, 19<u>57</u>, that I last saw the deceased alive on <u>1-2</u>, 19<u>57</u>, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willis R. Ellis</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u> DATE SIGNED <u>1-2-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Albans</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Mansel Co.</u>		ADDRESS <u>Salisbury, Md.</u>	
DATE <u>JAN 7 1957</u>							

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

1957

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

54. SIGNATURE OF INTERVIEWER

55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

58. SIGNATURE OF INTERVIEWER

59. SIGNATURE OF INTERVIEWER

60. SIGNATURE OF INTERVIEWER

61. SIGNATURE OF INTERVIEWER

BUREAU V. S.

JAN 7 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G210, 2/8/57 bh

CERTIFICATE OF DEATH

1259

01218

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		TOWN <u>Tyaskin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) <u>Lifetime</u>		STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Minnie Riall Hopkins</u>				<u>Jan. 23 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 2, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Riall</u>				14. MOTHER'S MAIDEN NAME <u>Martha Davis Riall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Earl Hopkins, Tyaskin, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Generalized</u>						<u>10 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>						<u>10 years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>2/18</u> , 19 <u>55</u> , to <u>1/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/23</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city, town, state) <u>Nantuxed</u> DATE SIGNED <u>1/25/57</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/57</u>		NAME OF CEMETERY OR CREMATORY <u>Saint Marys Cemetery</u>		LOCATION (City, town, or county) <u>Tyaskin, Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 4 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Talley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>	

CERTIFICATE OF DEATH

REG. NO. 10

LOCAL NUMBER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO BATH

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO LIVING ROOM

DATE OF ENTRY INTO DINING ROOM

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO POOL

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

DATE OF ENTRY INTO BALCONY

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO POOL

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

BUREAU V. 2

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01219

1220

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. STREET ADDRESS XO Allen 1 R.D.# (Box# 194)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle MAE Last HURLEY				4. DATE OF DEATH Month Jan. Day 26th Year 57			
5. SEX Female	6. COLOR OR RACE White6	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1914		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winter Haven Florida		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Charlie William Pressgray				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Clinton James Hurley (Husband) Box# 194 Allen, Maryland (Near Salisbury)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of cervix & metastases to lungs & breast. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/26/57 , 19 57 , to 1/26/57 , 19 57 , that I last saw the deceased alive on 1/26/57 , 19 57 , and that death occurred at 11:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William H. Fisher Jr.				M.D. Medical Center		DATE SIGNED Jan. 28 1957	
PHYSICIAN'S NAME (Type) William H. Fisher Jr.				M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		22d. LOCATION (City, town, or county) (State) Allen Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. RECORD BY REGISTRAR JAN 30 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. M.

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01220

1221

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WADE Middle HAMPTON Last INSLEY, Sr.		4. DATE OF DEATH Month 1 Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker		10b. KIND OF BUSINESS OR INDUSTRY Life-Commercial	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Dallas Insley		14. MOTHER'S MAIDEN NAME Susan Horsman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wade H. Insley, Jr.		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3-57 to 1-6-57 , that I last saw the deceased alive on 1-3-57 , and that death occurred at 7:2 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1-7-57			
ACTUAL SIGNATURE Philip A. Insley M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/8/1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR DATE 1-7-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloman	

•

BOREAU V.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01221
332

Reg. Dist. No.

1222

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>110 W. Laurel St.</u>				d. STREET ADDRESS <u>R.F.H. 1922</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>L.</u> Last <u>Jackson</u>				4. DATE OF DEATH Jan 19 1957			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 27 1920</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Id.</u>		11. BIRTHPLACE (State or foreign country) <u>Id.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William H. Miles</u>				14. MOTHER'S MAIDEN NAME <u>Martha P. Godwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Jackson</u> Address <u>Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>592 X</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC NEPHRITIS & UREMIA</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443 X</u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/16</u> , 19 <u>55</u> , to <u>1/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1/21/57</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u></u>							
PHYSICIAN'S NAME (Type) <u>O. J. Burton, M. D., 211 Maryland Ave., Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Int Vernon Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Benson</u> ADDRESS <u>Princess Anne</u>				24. REC'D BY REGISTRAR <u>7. 1/23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

BUREAU V. E.

JAN 24 1957

RECEIVED

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1223

CERTIFICATE OF DEATH

Reg. Dist. No. 332

01222

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>23X02</u>			
3. NAME OF DECEASED (Type or Print) <u>Annie</u> (First) <u>MARY</u> (Middle) <u>Jones</u> (Last)				4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>20</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Oct 1, 1881</u>	
9. AGE last birthday <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Roberts</u>			
14. MOTHER'S MAIDEN NAME <u>Herman Parker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown.) (If Yes, give war or dates of service) <u>217-14-8482</u>			
16. SOCIAL SECURITY NO. <u>217-14-8482</u>				17. INFORMANT'S ADDRESS <u>Harry Jones</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
570.2 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prolonged vomiting with electrolyte imbalance</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Irradiation obstruction from sup. Mesenteric artery</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardiovascular disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-18, 1957, to 1-20, 1957, that I last saw the deceased alive on 1-20, 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Eugene J. Linberg</u> M.D.				DATE SIGNED <u>1-24-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Jan 23</u>		LOCATION (City, town, or county) (State) <u>Whaleysville Md</u>	
24. REC'D BY REGISTRAR <u>1-25-57</u>		REGISTRAR'S SIGNATURE <u>Maryell Holman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u>		ADDRESS <u>Dorchester Md</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Sex

3. Age

4. Race

5. Date of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of County Clerk

16. Signature of Mayor

17. Signature of City Clerk

18. Signature of Town Clerk

19. Signature of Village Clerk

20. Signature of Ward Clerk

21. Signature of Precinct Clerk

22. Signature of Polling Place Clerk

23. Signature of Election Judge

24. Signature of Election Officer

25. Signature of Election Inspector

26. Signature of Election Agent

27. Signature of Election Clerk

28. Signature of Election Officer

29. Signature of Election Inspector

30. Signature of Election Agent

31. Signature of Election Clerk

32. Signature of Election Officer

33. Signature of Election Inspector

34. Signature of Election Agent

35. Signature of Election Clerk

36. Signature of Election Officer

37. Signature of Election Inspector

38. Signature of Election Agent

39. Signature of Election Clerk

40. Signature of Election Officer

41. Signature of Election Inspector

42. Signature of Election Agent

43. Signature of Election Clerk

44. Signature of Election Officer

BUREAU V. 1

JAN 28 1957

RECEIVED

SMITHSONIAN INSTITUTION

1224

CERTIFICATE OF DEATH

Reg. Dist. No.

327

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS 312 E. William St	
3. NAME OF DECEASED (Type or print) First MANORA Middle ALICE Last JUSTIS		4. DATE OF DEATH Month JANUARY Day 30th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator & Owner of		10b. KIND OF BUSINESS OR INDUSTRY Justis Apartment House	
11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William James Toadvine		14. MOTHER'S MAIDEN NAME Clara Emily Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Irma M. Bradley (Sister)		Address R.D.# 1 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c) Poroxysmal Auricular Tachycardia INTERVAL BETWEEN ONSET AND DEATH 4 wks 8-10 yrs "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal abscess, left kidney			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1 19 57 , to 1/30 19 57 , that I last saw the deceased alive on 1/30 19 57 , and that death occurred at 7:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D.		ADDRESS (Street, city or town, state) S. Division St. (Office) DATE SIGNED FEB 15 1957	
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR FEB 4 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01224

CERTIFICATE OF DEATH

1260

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
CITY OR TOWN <u>Tyaskin</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		STREET ADDRESS <u>/</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last) <u>Emma</u> <u>Larmore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>25</u> <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2/27/1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George E. Larmore</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hemmons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/19</u> , 19 <u>50</u> , to <u>1/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u> M.D. <u>Nantuxke Md.</u>				ADDRESS (Street, city, town, state) <u>1/27/57</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/27/57</u>		NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cemetery</u>		LOCATION (City, town, or county) <u>Tyaskin, Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 4 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Messick</u>		ADDRESS <u>Bivalve, Maryland</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL RESIDENCE (HOME) OF DECEASED

100

MARYLAND

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

BUREAU V. 3

1957

RECEIVED

1225 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>4 HRS.</u>		TOWN <u>DELMAR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>HOWARD JAMES MADDox</u>				<u>JANUARY 7 19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>White</u>	<u>MARRIED</u>	<u>4-6-1889</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>TOREMAN</u>		<u>RAILROAD</u>		<u>WICOMICO COUNTY</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GEORGE M. MADDox</u>				<u>OLEVIA CAMPBELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>716-01-9421</u>		<u>BERTIE A. MADDox-DELMAR</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>						<u>4 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerotic Coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-7</u> , 19 <u>57</u> , to <u>1-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-7</u> , 19 <u>57</u> , and that death occurred at <u>11:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>William R. Ellis</u>		<u>Salisbury, Md</u>		<u>1-7-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-10-1957</u>		<u>St. Olive</u>		<u>Delmar, Del</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 11 1957</u>		<u>Mary H. Holloway</u>		<u>W.S. Grand Co - Delmar, Del</u>		<u>Delmar, Del</u>	

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1933 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Case No. 123

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF BIRTH

12. AGE AT BIRTH

13. OCCUPATION AT BIRTH

14. CAUSE OF BIRTH

15. MANNER OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. SEX OF BIRTH

21. AGE AT BIRTH

22. OCCUPATION AT BIRTH

23. CAUSE OF BIRTH

24. MANNER OF BIRTH

25. DATE OF BIRTH

26. TIME OF BIRTH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX OF BIRTH

30. AGE AT BIRTH

31. OCCUPATION AT BIRTH

32. CAUSE OF BIRTH

33. MANNER OF BIRTH

34. DATE OF BIRTH

35. TIME OF BIRTH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. SEX OF BIRTH

39. AGE AT BIRTH

40. OCCUPATION AT BIRTH

41. CAUSE OF BIRTH

42. MANNER OF BIRTH

43. DATE OF BIRTH

44. TIME OF BIRTH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. SEX OF BIRTH

48. AGE AT BIRTH

49. OCCUPATION AT BIRTH

50. CAUSE OF BIRTH

51. MANNER OF BIRTH

52. DATE OF BIRTH

53. TIME OF BIRTH

54. PLACE OF BIRTH

55. DATE OF BIRTH

56. SEX OF BIRTH

57. AGE AT BIRTH

58. OCCUPATION AT BIRTH

59. CAUSE OF BIRTH

60. MANNER OF BIRTH

61. DATE OF BIRTH

62. TIME OF BIRTH

63. PLACE OF BIRTH

64. DATE OF BIRTH

65. SEX OF BIRTH

66. AGE AT BIRTH

67. OCCUPATION AT BIRTH

68. CAUSE OF BIRTH

69. MANNER OF BIRTH

70. DATE OF BIRTH

71. TIME OF BIRTH

72. PLACE OF BIRTH

73. DATE OF BIRTH

74. SEX OF BIRTH

75. AGE AT BIRTH

76. OCCUPATION AT BIRTH

77. CAUSE OF BIRTH

78. MANNER OF BIRTH

79. DATE OF BIRTH

80. TIME OF BIRTH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF BIRTH

84. AGE AT BIRTH

85. OCCUPATION AT BIRTH

86. CAUSE OF BIRTH

87. MANNER OF BIRTH

88. DATE OF BIRTH

89. TIME OF BIRTH

90. PLACE OF BIRTH

91. DATE OF BIRTH

92. SEX OF BIRTH

93. AGE AT BIRTH

94. OCCUPATION AT BIRTH

95. CAUSE OF BIRTH

96. MANNER OF BIRTH

97. DATE OF BIRTH

98. TIME OF BIRTH

99. PLACE OF BIRTH

100. DATE OF BIRTH

101. SEX OF BIRTH

102. AGE AT BIRTH

103. OCCUPATION AT BIRTH

104. CAUSE OF BIRTH

105. MANNER OF BIRTH

106. DATE OF BIRTH

107. TIME OF BIRTH

108. PLACE OF BIRTH

109. DATE OF BIRTH

110. SEX OF BIRTH

111. AGE AT BIRTH

112. OCCUPATION AT BIRTH

113. CAUSE OF BIRTH

114. MANNER OF BIRTH

115. DATE OF BIRTH

116. TIME OF BIRTH

117. PLACE OF BIRTH

118. DATE OF BIRTH

119. SEX OF BIRTH

120. AGE AT BIRTH

121. OCCUPATION AT BIRTH

122. CAUSE OF BIRTH

123. MANNER OF BIRTH

124. DATE OF BIRTH

125. TIME OF BIRTH

126. PLACE OF BIRTH

127. DATE OF BIRTH

128. SEX OF BIRTH

129. AGE AT BIRTH

130. OCCUPATION AT BIRTH

131. CAUSE OF BIRTH

132. MANNER OF BIRTH

133. DATE OF BIRTH

134. TIME OF BIRTH

135. PLACE OF BIRTH

136. DATE OF BIRTH

137. SEX OF BIRTH

138. AGE AT BIRTH

139. OCCUPATION AT BIRTH

140. CAUSE OF BIRTH

141. MANNER OF BIRTH

142. DATE OF BIRTH

143. TIME OF BIRTH

144. PLACE OF BIRTH

145. DATE OF BIRTH

146. SEX OF BIRTH

147. AGE AT BIRTH

148. OCCUPATION AT BIRTH

149. CAUSE OF BIRTH

150. MANNER OF BIRTH

151. DATE OF BIRTH

152. TIME OF BIRTH

153. PLACE OF BIRTH

154. DATE OF BIRTH

155. SEX OF BIRTH

156. AGE AT BIRTH

157. OCCUPATION AT BIRTH

158. CAUSE OF BIRTH

159. MANNER OF BIRTH

160. DATE OF BIRTH

161. TIME OF BIRTH

162. PLACE OF BIRTH

163. DATE OF BIRTH

164. SEX OF BIRTH

165. AGE AT BIRTH

166. OCCUPATION AT BIRTH

167. CAUSE OF BIRTH

168. MANNER OF BIRTH

169. DATE OF BIRTH

170. TIME OF BIRTH

171. PLACE OF BIRTH

172. DATE OF BIRTH

173. SEX OF BIRTH

174. AGE AT BIRTH

175. OCCUPATION AT BIRTH

176. CAUSE OF BIRTH

177. MANNER OF BIRTH

178. DATE OF BIRTH

179. TIME OF BIRTH

180. PLACE OF BIRTH

181. DATE OF BIRTH

182. SEX OF BIRTH

183. AGE AT BIRTH

184. OCCUPATION AT BIRTH

185. CAUSE OF BIRTH

186. MANNER OF BIRTH

187. DATE OF BIRTH

188. TIME OF BIRTH

189. PLACE OF BIRTH

190. DATE OF BIRTH

191. SEX OF BIRTH

192. AGE AT BIRTH

193. OCCUPATION AT BIRTH

194. CAUSE OF BIRTH

195. MANNER OF BIRTH

196. DATE OF BIRTH

197. TIME OF BIRTH

198. PLACE OF BIRTH

199. DATE OF BIRTH

200. SEX OF BIRTH

201. AGE AT BIRTH

202. OCCUPATION AT BIRTH

203. CAUSE OF BIRTH

204. MANNER OF BIRTH

205. DATE OF BIRTH

206. TIME OF BIRTH

207. PLACE OF BIRTH

208. DATE OF BIRTH

209. SEX OF BIRTH

210. AGE AT BIRTH

211. OCCUPATION AT BIRTH

212. CAUSE OF BIRTH

213. MANNER OF BIRTH

214. DATE OF BIRTH

215. TIME OF BIRTH

216. PLACE OF BIRTH

217. DATE OF BIRTH

218. SEX OF BIRTH

219. AGE AT BIRTH

220. OCCUPATION AT BIRTH

221. CAUSE OF BIRTH

222. MANNER OF BIRTH

223. DATE OF BIRTH

224. TIME OF BIRTH

225. PLACE OF BIRTH

226. DATE OF BIRTH

227. SEX OF BIRTH

228. AGE AT BIRTH

229. OCCUPATION AT BIRTH

230. CAUSE OF BIRTH

231. MANNER OF BIRTH

232. DATE OF BIRTH

233. TIME OF BIRTH

234. PLACE OF BIRTH

235. DATE OF BIRTH

236. SEX OF BIRTH

237. AGE AT BIRTH

238. OCCUPATION AT BIRTH

239. CAUSE OF BIRTH

240. MANNER OF BIRTH

241. DATE OF BIRTH

242. TIME OF BIRTH

243. PLACE OF BIRTH

244. DATE OF BIRTH

245. SEX OF BIRTH

246. AGE AT BIRTH

247. OCCUPATION AT BIRTH

248. CAUSE OF BIRTH

249. MANNER OF BIRTH

250. DATE OF BIRTH

251. TIME OF BIRTH

252. PLACE OF BIRTH

253. DATE OF BIRTH

254. SEX OF BIRTH

255. AGE AT BIRTH

256. OCCUPATION AT BIRTH

257. CAUSE OF BIRTH

258. MANNER OF BIRTH

259. DATE OF BIRTH

260. TIME OF BIRTH

261. PLACE OF BIRTH

262. DATE OF BIRTH

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1226 CERTIFICATE OF DEATH

01226

33r

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>14 days</u>		TOWN <u>Girdletree</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>23x02</u>			
3. NAME OF DECEASED (Type or Print) <u>AMANDA W. MARINER</u>				4. DATE OF DEATH (Month) <u>January</u> (Day) <u>10</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 25, 1860</u>	9. AGE last birthday <u>96</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lenox Ailsworth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Lang</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Rena Jackson, Girdletree, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21a. INJURY OCCURRED		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/31/1956</u> , to <u>1-10-1957</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>57</u> , and that death occurred at <u>1:35</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>1-17-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-17-57</u>		NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural Pocomoke City, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	

JAN 21 1957

CERTIFICATE OF DEATH

Form 10-57

1. PLACE OF BIRTH

2. DATE OF BIRTH

3. SEX

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF ASSISTANT CLERK

20. SIGNATURE OF RECEPTIONIST

21. SIGNATURE OF TELEPHONE OPERATOR

22. SIGNATURE OF MAIL ROOM

23. SIGNATURE OF RECORDS SECTION

24. SIGNATURE OF STATISTICS SECTION

25. SIGNATURE OF LABORATORY

26. SIGNATURE OF X-RAY DEPARTMENT

27. SIGNATURE OF RADIOLOGY DEPARTMENT

28. SIGNATURE OF PATHOLOGY DEPARTMENT

29. SIGNATURE OF BACTERIOLOGY DEPARTMENT

30. SIGNATURE OF VIROLOGY DEPARTMENT

31. SIGNATURE OF IMMUNOLOGY DEPARTMENT

32. SIGNATURE OF EPIDEMIOLOGY DEPARTMENT

33. SIGNATURE OF PUBLIC HEALTH DEPARTMENT

34. SIGNATURE OF HEALTH EDUCATION DEPARTMENT

35. SIGNATURE OF COMMUNITY HEALTH DEPARTMENT

36. SIGNATURE OF SCHOOL HEALTH DEPARTMENT

37. SIGNATURE OF INDUSTRIAL HEALTH DEPARTMENT

38. SIGNATURE OF OCCUPATIONAL HEALTH DEPARTMENT

39. SIGNATURE OF ENVIRONMENTAL HEALTH DEPARTMENT

40. SIGNATURE OF FOOD AND DRUG INSPECTION DEPARTMENT

41. SIGNATURE OF LABORATORY DEPARTMENT

42. SIGNATURE OF X-RAY DEPARTMENT

43. SIGNATURE OF RADIOLOGY DEPARTMENT

44. SIGNATURE OF PATHOLOGY DEPARTMENT

45. SIGNATURE OF BACTERIOLOGY DEPARTMENT

46. SIGNATURE OF VIROLOGY DEPARTMENT

47. SIGNATURE OF IMMUNOLOGY DEPARTMENT

48. SIGNATURE OF EPIDEMIOLOGY DEPARTMENT

49. SIGNATURE OF PUBLIC HEALTH DEPARTMENT

50. SIGNATURE OF HEALTH EDUCATION DEPARTMENT

51. SIGNATURE OF COMMUNITY HEALTH DEPARTMENT

52. SIGNATURE OF SCHOOL HEALTH DEPARTMENT

53. SIGNATURE OF INDUSTRIAL HEALTH DEPARTMENT

54. SIGNATURE OF OCCUPATIONAL HEALTH DEPARTMENT

55. SIGNATURE OF ENVIRONMENTAL HEALTH DEPARTMENT

56. SIGNATURE OF FOOD AND DRUG INSPECTION DEPARTMENT

57. SIGNATURE OF LABORATORY DEPARTMENT

58. SIGNATURE OF X-RAY DEPARTMENT

59. SIGNATURE OF RADIOLOGY DEPARTMENT

60. SIGNATURE OF PATHOLOGY DEPARTMENT

BUREAU V. A.

AN 21 1957

RECEIVED

RECEIVED

INSTRUCTIONS

1. TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

1227

01227

331

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>13 DAYS</u>		TOWN <u>Pocomoke, 23x02</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Route #2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertie</u> (Middle) <u>MT.</u> (Last) <u>MARRINER.</u>				(Month) <u>JANUARY</u> (Day) <u>26</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>white</u>	<u>MARRIED</u>	<u>SEPT. 25, 1895</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>				<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM GIBBONS</u>				<u>MARY ANN DRYDEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>MR. ADLIA S. MARINER, Pocomoke, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>12 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/13</u> , 19 <u>57</u> , to <u>1/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>57</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frederic R. Grammel</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>1/27/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1957-1-27-57</u>		<u>BAPTIST CEMETERY</u>		<u>Pocomoke, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 28 1957</u>		<u>Mary H. Holloway</u>		<u>Henry D. Watson</u>		<u>(Pocomoke, MD)</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

DATE OF DEATH

1. FULL RESIDENCE ADDRESS OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

BUREAU V. 3

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01228

1228

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 0 Mardela Springs (Rural)				d. STREET ADDRESS R.D. # Division St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIOLET Middle MARY Last NICHOLS				4. DATE OF DEATH Month Jan. Day 23, Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1885		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harding				14. MOTHER'S MAIDEN NAME Margaret Atchison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address 353 W. 56th Mrs. Marcelle Johnson (Niece) New York City NY Deer's Head Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Old cardiovascular accident							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 24, 1956 , to Jan. 23, 1957 , that I last saw the deceased alive on Jan. 23, 1957 , and that death occurred at 11:42A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 1/23/57							
ACTUAL SIGNATURE L. V. Maldve		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR AN 25 10		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

BUREAU V. S.

JAN 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01229

1229 CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		STATE <u>MARYLAND</u>		COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>3 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SNOW HILL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>23X02209 FEDERAL ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM Samuel PARSONS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 26 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 18-1877</u>	9. AGE last birthday <u>79 1/8</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md</u>	
13. FATHER'S NAME <u>George W. Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth C. Holston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>420-32-0718</u>		17. INFORMANT & ADDRESS <u>Miss Julia H. Parsons, Snow Hill, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4222 IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-4-57</u> , 19 <u>57</u> , to <u>1-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>57</u> , and that death occurred at <u>6:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>			
DATE <u>Jan 29/57</u>				DATE SIGNED <u>1-26-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 29/57</u>		NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR <u>JAN 29 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mayo Thomas</u>		ADDRESS <u>Snow Hill, Md</u>	

ENCLOSURE

RECEIVED
JAN 29 1957
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. DEATH OF DECEASED

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
RACE: [illegible]
ETHNIC ORIGIN: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
CERTIFICATE NO.: [illegible]

2. SIGNATURE OF DECEASED

RECEIVED
JAN 29 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01230

Reg. Dist. No.

1261

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# Salisbury (Walston)				d. STREET ADDRESS R.D.# 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY GOLDSBOROUGH PERDUE				4. DATE OF DEATH Month Day Year JANUARY 18th 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John James Perdue				14. MOTHER'S MAIDEN NAME Hester Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Irma M. Kelley (Daughter) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) arterio-sclerotic heart disease (c) arterio-sclerotic heart disease DUE TO causes listed.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED Jan. 19, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Salisbury (Walston) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD				24a. REC'D BY REGISTRAR Jan 21 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-11-57

RECEIVED
JAN 21 1957
BUREAU V. A.

1262
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01231
337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St		d. STREET ADDRESS Main St	
3. NAME OF DECEASED (Type or print) First SENERA Middle BELITHA Last PHILLIPS		4. DATE OF DEATH Month JAN. Day 20th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator (Employee)		10b. KIND OF BUSINESS OR INDUSTRY Pants Factory	
11. BIRTHPLACE (State or foreign country) Laurel, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fredrick B. Joseph		14. MOTHER'S MAIDEN NAME Hattie Ann Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Guss A. Phillips (Husband) Address Main St Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Nephritis DUE TO (c) Sarcoma of Intestinal Tract		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3rd 1957 to Jan 20 1957 , that I lost saw the deceased alive on Jan 20 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED NE Spitznagle MD (Office) Jan 21 1957			
ACTUAL SIGNATURE Dr. Vernon E. Spitznagle M.D. Mardela, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR Jan 22 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. COUNTY	
3. CITY OR TOWN		4. STATE	
5. DECEASED'S NAME		6. SEX	
7. AGE		8. DATE OF BIRTH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. PLACE OF BIRTH		12. DATE OF DEATH	
13. TIME OF DEATH		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY	
23. SIGNATURE OF DISTRICT ATTORNEY		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF COUNTY COMMISSIONER		26. SIGNATURE OF COUNTY SHERIFF	
27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF COUNTY COMMISSIONER	
29. SIGNATURE OF COUNTY SHERIFF		30. SIGNATURE OF COUNTY CLERK	
31. SIGNATURE OF COUNTY COMMISSIONER		32. SIGNATURE OF COUNTY SHERIFF	
33. SIGNATURE OF COUNTY CLERK		34. SIGNATURE OF COUNTY COMMISSIONER	
35. SIGNATURE OF COUNTY SHERIFF		36. SIGNATURE OF COUNTY CLERK	
37. SIGNATURE OF COUNTY COMMISSIONER		38. SIGNATURE OF COUNTY SHERIFF	
39. SIGNATURE OF COUNTY CLERK		40. SIGNATURE OF COUNTY COMMISSIONER	
41. SIGNATURE OF COUNTY SHERIFF		42. SIGNATURE OF COUNTY CLERK	
43. SIGNATURE OF COUNTY COMMISSIONER		44. SIGNATURE OF COUNTY SHERIFF	
45. SIGNATURE OF COUNTY CLERK		46. SIGNATURE OF COUNTY COMMISSIONER	
47. SIGNATURE OF COUNTY SHERIFF		48. SIGNATURE OF COUNTY CLERK	
49. SIGNATURE OF COUNTY COMMISSIONER		50. SIGNATURE OF COUNTY SHERIFF	
51. SIGNATURE OF COUNTY CLERK		52. SIGNATURE OF COUNTY COMMISSIONER	
53. SIGNATURE OF COUNTY SHERIFF		54. SIGNATURE OF COUNTY CLERK	
55. SIGNATURE OF COUNTY COMMISSIONER		56. SIGNATURE OF COUNTY SHERIFF	
57. SIGNATURE OF COUNTY CLERK		58. SIGNATURE OF COUNTY COMMISSIONER	
59. SIGNATURE OF COUNTY SHERIFF		60. SIGNATURE OF COUNTY CLERK	
61. SIGNATURE OF COUNTY COMMISSIONER		62. SIGNATURE OF COUNTY SHERIFF	
63. SIGNATURE OF COUNTY CLERK		64. SIGNATURE OF COUNTY COMMISSIONER	
65. SIGNATURE OF COUNTY SHERIFF		66. SIGNATURE OF COUNTY CLERK	
67. SIGNATURE OF COUNTY COMMISSIONER		68. SIGNATURE OF COUNTY SHERIFF	
69. SIGNATURE OF COUNTY CLERK		70. SIGNATURE OF COUNTY COMMISSIONER	
71. SIGNATURE OF COUNTY SHERIFF		72. SIGNATURE OF COUNTY CLERK	
73. SIGNATURE OF COUNTY COMMISSIONER		74. SIGNATURE OF COUNTY SHERIFF	
75. SIGNATURE OF COUNTY CLERK		76. SIGNATURE OF COUNTY COMMISSIONER	
77. SIGNATURE OF COUNTY SHERIFF		78. SIGNATURE OF COUNTY CLERK	
79. SIGNATURE OF COUNTY COMMISSIONER		80. SIGNATURE OF COUNTY SHERIFF	
81. SIGNATURE OF COUNTY CLERK		82. SIGNATURE OF COUNTY COMMISSIONER	
83. SIGNATURE OF COUNTY SHERIFF		84. SIGNATURE OF COUNTY CLERK	
85. SIGNATURE OF COUNTY COMMISSIONER		86. SIGNATURE OF COUNTY SHERIFF	
87. SIGNATURE OF COUNTY CLERK		88. SIGNATURE OF COUNTY COMMISSIONER	
89. SIGNATURE OF COUNTY SHERIFF		90. SIGNATURE OF COUNTY CLERK	
91. SIGNATURE OF COUNTY COMMISSIONER		92. SIGNATURE OF COUNTY SHERIFF	
93. SIGNATURE OF COUNTY CLERK		94. SIGNATURE OF COUNTY COMMISSIONER	
95. SIGNATURE OF COUNTY SHERIFF		96. SIGNATURE OF COUNTY CLERK	
97. SIGNATURE OF COUNTY COMMISSIONER		98. SIGNATURE OF COUNTY SHERIFF	
99. SIGNATURE OF COUNTY CLERK		100. SIGNATURE OF COUNTY COMMISSIONER	

BUREAU V. S.

JAN 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1230

CERTIFICATE OF DEATH

01232

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS Pemberton Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRAHAM Middle JOHN Last PRETTYMAN		4. DATE OF DEATH Month JAN. Day 5 th Year 19 54 7	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, 1910
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Employee)		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ray Prettyman		14. MOTHER'S MAIDEN NAME Maude Figgs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Informant	
17. ADDRESS Mrs. Inez J. Prettyman (Wife) Pemberton Drive Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prophaged varices DUE TO (c) cirrhosis of the liver		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mos 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25 , 19 56 , to 1/5 , 19 57 , that I last saw the deceased alive on 1/4 , 19 57 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Maryland Ave. (Office)		DATE SIGNED Jan. 5, 1957	
ACTUAL SIGNATURE Earl Beardsley M.D.			
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE N 8 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 11

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1231

CERTIFICATE OF DEATH

Reg. Dist. No.

01233

332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>648 S. Salisbury Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>REIGART</u> Middle <u>HENRY</u> Last <u>RIDER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1893</u>	
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u>1957</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>22</u> Hours <u>1957</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Distributor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Rider</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Fessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. R.H. Rider, Same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/15/53</u> , 19 <u>53</u> , to <u>1/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/23</u> , 19 <u>57</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>1/24/57</u>							
ACTUAL SIGNATURE <u>A. C. Mitchell</u> M.D. <u>Salisbury, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell, 211 Maryland Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR <u>1-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

Norman T. Baker

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. 1

JAN 28 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
HARRY ALTON		JAN 28 1957		BALTIMORE, MD	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 15 1892		BALTIMORE, MD		U.S.A.	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
JAN 15 1915		BALTIMORE, MD		U.S.A.	
OCCUPATION		EDUCATION		RELIGION	
Carpenter		High School		Roman Catholic	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
Myocardial Infarction		Natural		12345	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Coronary Atherosclerosis		Hypertension		Atherosclerosis	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. H. Smith, M.D.		J. H. Smith, M.D.		JAN 28 1957	

1232

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - 109 Morris Lane				d. STREET ADDRESS 109 Morris Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frances Middle Emily Last Roberts				4. DATE OF DEATH Month 1 Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE A.A.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 6 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Cook		11. BIRTHPLACE (State or foreign country) Oriole, Somerset Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Roberts				14. MOTHER'S MAIDEN NAME Mary Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Morgan State College	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957 , to 1-21 , 19 57 , that I last saw the deceased alive on 1-20 , 19 57 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 1-23-57			
PHYSICIAN'S NAME (Type) Philip A. Insley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-57		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery		22d. LOCATION (City, town, or county) (State) Oriole, Somerset Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE 24 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Hallways							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1233

CERTIFICATE OF DEATH

01235

Dr. C. J. Burton M.D.

Reg. Dist. No. 237

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS <u>647 Fitzwater Street</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ORA</u> <u>LILLIAN</u> <u>Ryall</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 21</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 20, 1891</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>R.D. # White Haven, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles H. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Reese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Robert B. Ryall (Husband) 647 Fitzwater St. Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ATHEROSCLEROSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HYPERTENSIVE CARDIO VASCULAR ATHEROSCLEROTIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>1/21/57</u> , that I last saw the deceased alive on <u>1/21/57</u> , and that death occurred at <u>12:57</u> A.M. , from the causes and on the date stated above. SIGNATURE <u>Dr. C. J. Burton M.D.</u> ADDRESS (Street, city, town, state) <u>211 Maryland Ave. Salisbury, Maryland</u> DATE SIGNED <u>January 21, 1957</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 24, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Fruitland Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fruitland Maryland</u>	
24. REC'D BY REGISTRAR <u>DATE JAN 23 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY, MARYLAND</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

WISCONSIN

WISCONSIN

Hennepin General Hospital

CR

Female

White

April

January 21

441 Alexander Street

WISCONSIN

WISCONSIN

WISCONSIN

ATHEROSCLEROSIS
CORONARY ATHEROSCLEROSIS
MYOCARDIAL INFARCTION

BUREAU V. 81

JAN 23 1957

RECEIVED

15-20

1/21

[Signature]

1907-1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01236

Reg. Dist. No.

337

1234

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Newborn</u> Middle <u>Baby John</u> Last <u>Sheffield</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-56</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Sherman Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lee Sheffield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James Mac Daniel, Nanticoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>6 hours</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				DATE SIGNED <u>1-7-57</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick, Bivona, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallways</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 18 1957

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1235

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>10 Min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>		d. STREET ADDRESS <u>205 E. Isabella St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>TILGHMAN</u> Last <u>SMACK</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Mar. 5, 1886</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Irma Tilghman, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure myocardial degeneration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/5</u> , 19 <u>56</u> , to <u>1/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl W. Beardsley</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>1/21/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earl Beardsley, 207 Maryland Ave., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill & Johnson Co, Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 1-20-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

JAN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01238

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 408 Goldsborough	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Smith		4. DATE OF DEATH Month Jan. Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Meade Bayne		14. MOTHER'S MAIDEN NAME Anna Singleton Bayne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25, 19 56 , to Jan. 2, 19 57 , that I last saw the deceased alive on Jan. 2, 19 57 , and that death occurred at 10:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/2/57	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 5 19 57	
22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son		24a. REC'D BY REGISTRAR Jan 8 19 57	
ADDRESS Easton Md		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

[illegible]

BUREAU V. 51

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01239
332

1237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland 17x02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS unk	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Mae Last Smith		4. DATE OF DEATH Month Jan. Day 21 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alpheus Andrews		14. MOTHER'S MAIDEN NAME Mary Mae Magnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital Records		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Ca. of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 170X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? Y YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Aug. 83, 19 56, to Jan 21, 19 57, that I last saw the deceased alive on Jan, 21, 19 57, and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Salisbury, Md. Jan. 22, 1957			
ACTUAL SIGNATURE L. V. Maldve		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 24	Crumpton	Crumpton Ind.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill Ind.	
24a. REC'D BY REGISTRAR DATE JAN 24 1957		24b. REGISTRAR'S SIGNATURE Mary H. Hollaway	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 24 1957		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		M		W	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JAN 24 1892		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE	
RETIRED		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 24 1957	

BUREAU V. S.

JAN 24 1957

RECEIVED

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01240

332

Reg. Dist. No.

1238

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>7 days</u>		TOWN <u>DELMAR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>46X-3 R 7 D # 1</u>			
3. NAME OF DECEASED (Type or Print) <u>Ethel S. Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 13TH 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-10-1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DELMAR - DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSIAH KENNEY</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE SIRMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>CHAS V. SMITH - DELMAR-DEL.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>William B. Ellis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>1-13-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-16-1957</u>		NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		LOCATION (City, town, or county) (State) <u>DELMAR - DEL.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del</u>		ADDRESS	
DATE <u>JAN 17 1957</u>							

JAN 17 1957

RECEIVED

1239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>19 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19-39-2 Crisfield</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>John B. Parsons Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MYRA</u> Middle <u>STERLING</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1866</u>			
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Leonard Sterling</u>				14. MOTHER'S MAIDEN NAME <u>Elena Cullen</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records John B. Parsons Home, Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1925</u> , 19 <u>25</u> , to <u>1/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/25/56</u> , 19 <u>56</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>1/25/57</u>									
ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D. <u>Salisbury, Maryland</u>				PHYSICIAN'S NAME (Type) <u>Dr. Fred Gramse, 402 South Division St., Salisbury, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>Norman F. Baker</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 28 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01242

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1240

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Princess Anne 19x02</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 56 R.D. #2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>XXXXXX</u> <u>Stewart</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January-29-1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>January 27, 1957</u>	9. AGE last birthday — yrs. —	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Mary Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
760.0 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral edema and atelectasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Intrauterine Anoxia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prolonged labor + Sepsis of Mother</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 27, 1957</u> , to <u>Jan 29, 1957</u> , that I last saw the deceased alive on <u>Jan 29, 1957</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>1/31/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>1/31/57</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. REC'D BY REGISTRAR DATE <u>1-31-57</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	

2082161XV5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1241 CERTIFICATE OF DEATH

Reg. Dist. No. 012433 ✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>3 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DELMAR</u>		<u>46X3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R7D#2</u>			
3. NAME OF DECEASED (Type or Print) <u>Joseph R Stokes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 5TH 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9-6-1904</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXTERMINATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RODENT</u>		11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND-MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH H. STOKES</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET RICKNOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>165-07-5470</u>		17. INFORMANT & ADDRESS <u>MARIE STOKES-DELMAR-DEL</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
451X IMMEDIATE CAUSE (A) <u>Hemorrhage both pleural Cavities</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rupture of Dissecting Aortic Aneurysm</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atherosclerosis of Aorta</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Crownary Artery Heart Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>1:07 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>Jan 5, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-9-1957</u>		NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		LOCATION (City, town, or county) (State) <u>DELMAR-DEL.</u>	
24. REC'D BY REGISTRAR <u>Jan 11 1957</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Granel Co - Delmar, Del</u>		ADDRESS	

1911 - CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF BIRTH

3. SEX (MALE OR FEMALE)

4. AGE (YEARS)

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF COUNTY

23. SIGNATURE OF CITY

24. SIGNATURE OF TOWNSHIP

25. SIGNATURE OF PARISH

26. SIGNATURE OF VILLAGE

27. SIGNATURE OF HAMLET

28. SIGNATURE OF CENSUS TRACT

29. SIGNATURE OF BLOCK

30. SIGNATURE OF HOUSE

31. SIGNATURE OF ROOM

32. SIGNATURE OF APARTMENT

33. SIGNATURE OF BUILDING

34. SIGNATURE OF LOT

35. SIGNATURE OF TRACT

36. SIGNATURE OF SECTION

37. SIGNATURE OF QUARTER

38. SIGNATURE OF SUBDIVISION

39. SIGNATURE OF BLOCK

40. SIGNATURE OF LOT

41. SIGNATURE OF TRACT

42. SIGNATURE OF SECTION

43. SIGNATURE OF QUARTER

44. SIGNATURE OF SUBDIVISION

45. SIGNATURE OF BLOCK

46. SIGNATURE OF LOT

47. SIGNATURE OF TRACT

48. SIGNATURE OF SECTION

49. SIGNATURE OF QUARTER

50. SIGNATURE OF SUBDIVISION

51. SIGNATURE OF BLOCK

52. SIGNATURE OF LOT

53. SIGNATURE OF TRACT

54. SIGNATURE OF SECTION

55. SIGNATURE OF QUARTER

56. SIGNATURE OF SUBDIVISION

57. SIGNATURE OF BLOCK

58. SIGNATURE OF LOT

59. SIGNATURE OF TRACT

60. SIGNATURE OF SECTION

61. SIGNATURE OF QUARTER

62. SIGNATURE OF SUBDIVISION

63. SIGNATURE OF BLOCK

64. SIGNATURE OF LOT

65. SIGNATURE OF TRACT

66. SIGNATURE OF SECTION

67. SIGNATURE OF QUARTER

68. SIGNATURE OF SUBDIVISION

69. SIGNATURE OF BLOCK

70. SIGNATURE OF LOT

71. SIGNATURE OF TRACT

72. SIGNATURE OF SECTION

73. SIGNATURE OF QUARTER

74. SIGNATURE OF SUBDIVISION

75. SIGNATURE OF BLOCK

76. SIGNATURE OF LOT

77. SIGNATURE OF TRACT

78. SIGNATURE OF SECTION

79. SIGNATURE OF QUARTER

80. SIGNATURE OF SUBDIVISION

RECEIVED

BUREAU V. S.

JAN 11 1957

RECEIVED

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 3-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1242

CERTIFICATE OF DEATH

01244

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u> COUNTY <u>Accomack</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HORNTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>83X-3</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby Boy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 3 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>		8. DATE OF BIRTH <u>JANUARY 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday yrs. <u>1</u>		IF UNDER 1 YEAR Months Days <u>1</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Earl Strautz</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Justice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A) <u>Electrocardiogram, congenital</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Cerebral anoxia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Prematurity (Birth Wt 7 lbs)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/3/57</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/2/57</u>, to <u>1/3/57</u>, that I last saw the deceased alive on <u>1/3/57</u>, 19<u>57</u>, and that death occurred at <u>2:40 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>William B. Salzman Jr.</u>				ADDRESS (Street, city, town, state) <u>Division St. Salisbury</u> DATE SIGNED <u>1/3/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-5-57</u>		NAME OF CEMETERY OR CREMATORY <u>Downing</u>		LOCATION (City, town, or county) (State) <u>Oak Hall</u>	
24. REC'D BY REGISTRAR <u>1-12-57</u>		REGISTRAR'S SIGNATURE <u>Mary H. Asloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salzman Jr.</u>		ADDRESS <u>Chesapeake</u>	

2082261XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. PLACE OF BIRTH

MARYLAND

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DEATH CERTIFICATE

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF JAILER

19. SIGNATURE OF WARDEN

20. SIGNATURE OF CHIEF OF POLICE

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWN CLERK

24. SIGNATURE OF VILLAGE CLERK

25. SIGNATURE OF CITY CLERK

26. SIGNATURE OF STATE CLERK

27. SIGNATURE OF FEDERAL CLERK

28. SIGNATURE OF MARSHAL

29. SIGNATURE OF DEPUTY MARSHAL

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF JAILER

33. SIGNATURE OF WARDEN

34. SIGNATURE OF CHIEF OF POLICE

35. SIGNATURE OF DISTRICT ATTORNEY

36. SIGNATURE OF COUNTY CLERK

37. SIGNATURE OF TOWN CLERK

38. SIGNATURE OF VILLAGE CLERK

39. SIGNATURE OF CITY CLERK

40. SIGNATURE OF STATE CLERK

41. SIGNATURE OF FEDERAL CLERK

42. SIGNATURE OF MARSHAL

43. SIGNATURE OF DEPUTY MARSHAL

44. SIGNATURE OF SHERIFF

45. SIGNATURE OF DEPUTY SHERIFF

46. SIGNATURE OF JAILER

47. SIGNATURE OF WARDEN

48. SIGNATURE OF CHIEF OF POLICE

49. SIGNATURE OF DISTRICT ATTORNEY

50. SIGNATURE OF COUNTY CLERK

51. SIGNATURE OF TOWN CLERK

52. SIGNATURE OF VILLAGE CLERK

53. SIGNATURE OF CITY CLERK

54. SIGNATURE OF STATE CLERK

55. SIGNATURE OF FEDERAL CLERK

56. SIGNATURE OF MARSHAL

57. SIGNATURE OF DEPUTY MARSHAL

58. SIGNATURE OF SHERIFF

59. SIGNATURE OF DEPUTY SHERIFF

60. SIGNATURE OF JAILER

61. SIGNATURE OF WARDEN

62. SIGNATURE OF CHIEF OF POLICE

63. SIGNATURE OF DISTRICT ATTORNEY

64. SIGNATURE OF COUNTY CLERK

65. SIGNATURE OF TOWN CLERK

66. SIGNATURE OF VILLAGE CLERK

67. SIGNATURE OF CITY CLERK

68. SIGNATURE OF STATE CLERK

69. SIGNATURE OF FEDERAL CLERK

70. SIGNATURE OF MARSHAL

71. SIGNATURE OF DEPUTY MARSHAL

72. SIGNATURE OF SHERIFF

73. SIGNATURE OF DEPUTY SHERIFF

74. SIGNATURE OF JAILER

75. SIGNATURE OF WARDEN

76. SIGNATURE OF CHIEF OF POLICE

77. SIGNATURE OF DISTRICT ATTORNEY

78. SIGNATURE OF COUNTY CLERK

79. SIGNATURE OF TOWN CLERK

80. SIGNATURE OF VILLAGE CLERK

81. SIGNATURE OF CITY CLERK

82. SIGNATURE OF STATE CLERK

83. SIGNATURE OF FEDERAL CLERK

84. SIGNATURE OF MARSHAL

85. SIGNATURE OF DEPUTY MARSHAL

86. SIGNATURE OF SHERIFF

87. SIGNATURE OF DEPUTY SHERIFF

88. SIGNATURE OF JAILER

89. SIGNATURE OF WARDEN

90. SIGNATURE OF CHIEF OF POLICE

91. SIGNATURE OF DISTRICT ATTORNEY

92. SIGNATURE OF COUNTY CLERK

93. SIGNATURE OF TOWN CLERK

94. SIGNATURE OF VILLAGE CLERK

95. SIGNATURE OF CITY CLERK

96. SIGNATURE OF STATE CLERK

97. SIGNATURE OF FEDERAL CLERK

98. SIGNATURE OF MARSHAL

99. SIGNATURE OF DEPUTY MARSHAL

100. SIGNATURE OF SHERIFF

101. SIGNATURE OF DEPUTY SHERIFF

102. SIGNATURE OF JAILER

103. SIGNATURE OF WARDEN

104. SIGNATURE OF CHIEF OF POLICE

105. SIGNATURE OF DISTRICT ATTORNEY

106. SIGNATURE OF COUNTY CLERK

107. SIGNATURE OF TOWN CLERK

108. SIGNATURE OF VILLAGE CLERK

109. SIGNATURE OF CITY CLERK

110. SIGNATURE OF STATE CLERK

111. SIGNATURE OF FEDERAL CLERK

112. SIGNATURE OF MARSHAL

113. SIGNATURE OF DEPUTY MARSHAL

114. SIGNATURE OF SHERIFF

115. SIGNATURE OF DEPUTY SHERIFF

116. SIGNATURE OF JAILER

117. SIGNATURE OF WARDEN

118. SIGNATURE OF CHIEF OF POLICE

119. SIGNATURE OF DISTRICT ATTORNEY

120. SIGNATURE OF COUNTY CLERK

121. SIGNATURE OF TOWN CLERK

122. SIGNATURE OF VILLAGE CLERK

123. SIGNATURE OF CITY CLERK

124. SIGNATURE OF STATE CLERK

125. SIGNATURE OF FEDERAL CLERK

126. SIGNATURE OF MARSHAL

127. SIGNATURE OF DEPUTY MARSHAL

128. SIGNATURE OF SHERIFF

129. SIGNATURE OF DEPUTY SHERIFF

130. SIGNATURE OF JAILER

131. SIGNATURE OF WARDEN

132. SIGNATURE OF CHIEF OF POLICE

133. SIGNATURE OF DISTRICT ATTORNEY

134. SIGNATURE OF COUNTY CLERK

135. SIGNATURE OF TOWN CLERK

136. SIGNATURE OF VILLAGE CLERK

137. SIGNATURE OF CITY CLERK

138. SIGNATURE OF STATE CLERK

139. SIGNATURE OF FEDERAL CLERK

140. SIGNATURE OF MARSHAL

141. SIGNATURE OF DEPUTY MARSHAL

142. SIGNATURE OF SHERIFF

143. SIGNATURE OF DEPUTY SHERIFF

144. SIGNATURE OF JAILER

145. SIGNATURE OF WARDEN

146. SIGNATURE OF CHIEF OF POLICE

147. SIGNATURE OF DISTRICT ATTORNEY

148. SIGNATURE OF COUNTY CLERK

149. SIGNATURE OF TOWN CLERK

150. SIGNATURE OF VILLAGE CLERK

151. SIGNATURE OF CITY CLERK

152. SIGNATURE OF STATE CLERK

153. SIGNATURE OF FEDERAL CLERK

154. SIGNATURE OF MARSHAL

155. SIGNATURE OF DEPUTY MARSHAL

156. SIGNATURE OF SHERIFF

157. SIGNATURE OF DEPUTY SHERIFF

158. SIGNATURE OF JAILER

159. SIGNATURE OF WARDEN

160. SIGNATURE OF CHIEF OF POLICE

161. SIGNATURE OF DISTRICT ATTORNEY

162. SIGNATURE OF COUNTY CLERK

163. SIGNATURE OF TOWN CLERK

164. SIGNATURE OF VILLAGE CLERK

165. SIGNATURE OF CITY CLERK

166. SIGNATURE OF STATE CLERK

167. SIGNATURE OF FEDERAL CLERK

168. SIGNATURE OF MARSHAL

169. SIGNATURE OF DEPUTY MARSHAL

170. SIGNATURE OF SHERIFF

171. SIGNATURE OF DEPUTY SHERIFF

172. SIGNATURE OF JAILER

173. SIGNATURE OF WARDEN

174. SIGNATURE OF CHIEF OF POLICE

175. SIGNATURE OF DISTRICT ATTORNEY

176. SIGNATURE OF COUNTY CLERK

177. SIGNATURE OF TOWN CLERK

178. SIGNATURE OF VILLAGE CLERK

179. SIGNATURE OF CITY CLERK

180. SIGNATURE OF STATE CLERK

181. SIGNATURE OF FEDERAL CLERK

182. SIGNATURE OF MARSHAL

183. SIGNATURE OF DEPUTY MARSHAL

184. SIGNATURE OF SHERIFF

185. SIGNATURE OF DEPUTY SHERIFF

186. SIGNATURE OF JAILER

187. SIGNATURE OF WARDEN

188. SIGNATURE OF CHIEF OF POLICE

189. SIGNATURE OF DISTRICT ATTORNEY

190. SIGNATURE OF COUNTY CLERK

191. SIGNATURE OF TOWN CLERK

192. SIGNATURE OF VILLAGE CLERK

193. SIGNATURE OF CITY CLERK

194. SIGNATURE OF STATE CLERK

195. SIGNATURE OF FEDERAL CLERK

196. SIGNATURE OF MARSHAL

197. SIGNATURE OF DEPUTY MARSHAL

198. SIGNATURE OF SHERIFF

199. SIGNATURE OF DEPUTY SHERIFF

200. SIGNATURE OF JAILER

201. SIGNATURE OF WARDEN

202. SIGNATURE OF CHIEF OF POLICE

203. SIGNATURE OF DISTRICT ATTORNEY

204. SIGNATURE OF COUNTY CLERK

205. SIGNATURE OF TOWN CLERK

206. SIGNATURE OF VILLAGE CLERK

207. SIGNATURE OF CITY CLERK

208. SIGNATURE OF STATE CLERK

209. SIGNATURE OF FEDERAL CLERK

210. SIGNATURE OF MARSHAL

211. SIGNATURE OF DEPUTY MARSHAL

212. SIGNATURE OF SHERIFF

213. SIGNATURE OF DEPUTY SHERIFF

214. SIGNATURE OF JAILER

215. SIGNATURE OF WARDEN

216. SIGNATURE OF CHIEF OF POLICE

217. SIGNATURE OF DISTRICT ATTORNEY

218. SIGNATURE OF COUNTY CLERK

219. SIGNATURE OF TOWN CLERK

220. SIGNATURE OF VILLAGE CLERK

221. SIGNATURE OF CITY CLERK

222. SIGNATURE OF STATE CLERK

223. SIGNATURE OF FEDERAL CLERK

224. SIGNATURE OF MARSHAL

225. SIGNATURE OF DEPUTY MARSHAL

226. SIGNATURE OF SHERIFF

227. SIGNATURE OF DEPUTY SHERIFF

228. SIGNATURE OF JAILER

229. SIGNATURE OF WARDEN

230. SIGNATURE OF CHIEF OF POLICE

231. SIGNATURE OF DISTRICT ATTORNEY

232. SIGNATURE OF COUNTY CLERK

233. SIGNATURE OF TOWN CLERK

234. SIGNATURE OF VILLAGE CLERK

235. SIGNATURE OF CITY CLERK

236. SIGNATURE OF STATE CLERK

237. SIGNATURE OF FEDERAL CLERK

238. SIGNATURE OF MARSHAL

239. SIGNATURE OF DEPUTY MARSHAL

240. SIGNATURE OF SHERIFF

241. SIGNATURE OF DEPUTY SHERIFF

242. SIGNATURE OF JAILER

243. SIGNATURE OF WARDEN

244. SIGNATURE OF CHIEF OF POLICE

245. SIGNATURE OF DISTRICT ATTORNEY

246. SIGNATURE OF COUNTY CLERK

247. SIGNATURE OF TOWN CLERK

248. SIGNATURE OF VILLAGE CLERK

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1243

CERTIFICATE OF DEATH

01245

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Worcester</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (If this place) <u>2 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>23X02</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u> (Middle) <u>W.</u> (Last) <u>Stungis</u>				(Month) <u>January</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 15 - 1895</u>	9. AGE last birthday <u>61 1/2</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ronald Mill Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Powellville, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William C. Stungis</u>				14. MOTHER'S MAIDEN NAME <u>Olivera E. Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-6144</u>		17. INFORMANT & ADDRESS <u>Mrs. Ella S. Gravenor, Snow Hill, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Insufficiency</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Sanguine + cellulitis left leg</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/4/1956</u> , to <u>1-24-1957</u> , that I last saw the deceased alive on <u>1-19-1957</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>James J. Beluore</u>				M.D.		DATE SIGNED <u>Jan. 24, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 27/57</u>		<u>White Mt Methodist</u>		<u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 28 1957</u>		<u>Mary H. Holloway</u>		<u>May E. Dammie</u>		<u>Snow Hill, Md</u>	

CERTIFICATE OF DEATH

1913

Form One, 1913

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX
4. AGE
5. OCCUPATION
6. COLOR
7. BIRTH DATE
8. BIRTH PLACE

9. MARITAL STATUS

10. DATE OF DEATH
11. TIME OF DEATH
12. CAUSE OF DEATH

13. PLACE OF BIRTH
14. DATE OF BIRTH
15. TIME OF BIRTH

16. PLACE OF DEATH

17. DATE OF DEATH
18. TIME OF DEATH
19. CAUSE OF DEATH

20. PLACE OF BIRTH
21. DATE OF BIRTH
22. TIME OF BIRTH

23. PLACE OF DEATH

24. DATE OF DEATH
25. TIME OF DEATH
26. CAUSE OF DEATH

27. PLACE OF BIRTH
28. DATE OF BIRTH
29. TIME OF BIRTH

30. PLACE OF DEATH

31. DATE OF DEATH
32. TIME OF DEATH
33. CAUSE OF DEATH

34. PLACE OF BIRTH
35. DATE OF BIRTH
36. TIME OF BIRTH

37. PLACE OF DEATH

38. DATE OF DEATH
39. TIME OF DEATH
40. CAUSE OF DEATH

41. PLACE OF BIRTH
42. DATE OF BIRTH
43. TIME OF BIRTH

44. PLACE OF DEATH

45. DATE OF DEATH
46. TIME OF DEATH
47. CAUSE OF DEATH

48. PLACE OF BIRTH
49. DATE OF BIRTH
50. TIME OF BIRTH

51. PLACE OF DEATH

52. DATE OF DEATH
53. TIME OF DEATH
54. CAUSE OF DEATH

55. PLACE OF BIRTH
56. DATE OF BIRTH
57. TIME OF BIRTH

58. PLACE OF DEATH

59. DATE OF DEATH
60. TIME OF DEATH
61. CAUSE OF DEATH

ENCLOSURE

RECEIVED JAN 28 1957

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11248**

1244

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS Calvert St	
3. NAME OF DECEASED (Type or print) First GEORGE Middle NATHANIEL Last VETRA		4. DATE OF DEATH Month JANUARY Day 31st Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Deal Island, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George N. Vetra		14. MOTHER'S MAIDEN NAME Ella L. Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes (If yes, give war or dates of service) W/W. I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Nelson D. Vetra (Son) Address 411 Virginia Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 168X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/29 , 19 57 , to 1/31 , 19 57 , that I last saw the deceased alive on 1/31 , 19 57 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St. (Office) Salisbury, Maryland DATE SIGNED Feb. 1st 1957 ACTUAL SIGNATURE Fred R. Gramse M.D. PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD ADDRESS		24a. REC'D BY REGISTRAR DATE 1 1957	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MEDICAL HISTORY [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF REGISTRAR [Illegible]		12. DATE OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF NEXT OF KIN [Illegible]	
17. SIGNATURE OF BURIAL OFFICIAL [Illegible]		18. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
19. SIGNATURE OF MINISTER [Illegible]		20. SIGNATURE OF CLERGYMAN [Illegible]	
21. SIGNATURE OF CHURCH OFFICIAL [Illegible]		22. SIGNATURE OF MINISTER [Illegible]	
23. SIGNATURE OF CLERGYMAN [Illegible]		24. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
25. SIGNATURE OF MINISTER [Illegible]		26. SIGNATURE OF CLERGYMAN [Illegible]	
27. SIGNATURE OF CHURCH OFFICIAL [Illegible]		28. SIGNATURE OF MINISTER [Illegible]	
29. SIGNATURE OF CLERGYMAN [Illegible]		30. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
31. SIGNATURE OF MINISTER [Illegible]		32. SIGNATURE OF CLERGYMAN [Illegible]	
33. SIGNATURE OF CHURCH OFFICIAL [Illegible]		34. SIGNATURE OF MINISTER [Illegible]	
35. SIGNATURE OF CLERGYMAN [Illegible]		36. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
37. SIGNATURE OF MINISTER [Illegible]		38. SIGNATURE OF CLERGYMAN [Illegible]	
39. SIGNATURE OF CHURCH OFFICIAL [Illegible]		40. SIGNATURE OF MINISTER [Illegible]	
41. SIGNATURE OF CLERGYMAN [Illegible]		42. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
43. SIGNATURE OF MINISTER [Illegible]		44. SIGNATURE OF CLERGYMAN [Illegible]	
45. SIGNATURE OF CHURCH OFFICIAL [Illegible]		46. SIGNATURE OF MINISTER [Illegible]	
47. SIGNATURE OF CLERGYMAN [Illegible]		48. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
49. SIGNATURE OF MINISTER [Illegible]		50. SIGNATURE OF CLERGYMAN [Illegible]	
51. SIGNATURE OF CHURCH OFFICIAL [Illegible]		52. SIGNATURE OF MINISTER [Illegible]	
53. SIGNATURE OF CLERGYMAN [Illegible]		54. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
55. SIGNATURE OF MINISTER [Illegible]		56. SIGNATURE OF CLERGYMAN [Illegible]	
57. SIGNATURE OF CHURCH OFFICIAL [Illegible]		58. SIGNATURE OF MINISTER [Illegible]	
59. SIGNATURE OF CLERGYMAN [Illegible]		60. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
61. SIGNATURE OF MINISTER [Illegible]		62. SIGNATURE OF CLERGYMAN [Illegible]	
63. SIGNATURE OF CHURCH OFFICIAL [Illegible]		64. SIGNATURE OF MINISTER [Illegible]	
65. SIGNATURE OF CLERGYMAN [Illegible]		66. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
67. SIGNATURE OF MINISTER [Illegible]		68. SIGNATURE OF CLERGYMAN [Illegible]	
69. SIGNATURE OF CHURCH OFFICIAL [Illegible]		70. SIGNATURE OF MINISTER [Illegible]	
71. SIGNATURE OF CLERGYMAN [Illegible]		72. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
73. SIGNATURE OF MINISTER [Illegible]		74. SIGNATURE OF CLERGYMAN [Illegible]	
75. SIGNATURE OF CHURCH OFFICIAL [Illegible]		76. SIGNATURE OF MINISTER [Illegible]	
77. SIGNATURE OF CLERGYMAN [Illegible]		78. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
79. SIGNATURE OF MINISTER [Illegible]		80. SIGNATURE OF CLERGYMAN [Illegible]	
81. SIGNATURE OF CHURCH OFFICIAL [Illegible]		82. SIGNATURE OF MINISTER [Illegible]	
83. SIGNATURE OF CLERGYMAN [Illegible]		84. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
85. SIGNATURE OF MINISTER [Illegible]		86. SIGNATURE OF CLERGYMAN [Illegible]	
87. SIGNATURE OF CHURCH OFFICIAL [Illegible]		88. SIGNATURE OF MINISTER [Illegible]	
89. SIGNATURE OF CLERGYMAN [Illegible]		90. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
91. SIGNATURE OF MINISTER [Illegible]		92. SIGNATURE OF CLERGYMAN [Illegible]	
93. SIGNATURE OF CHURCH OFFICIAL [Illegible]		94. SIGNATURE OF MINISTER [Illegible]	
95. SIGNATURE OF CLERGYMAN [Illegible]		96. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
97. SIGNATURE OF MINISTER [Illegible]		98. SIGNATURE OF CLERGYMAN [Illegible]	
99. SIGNATURE OF CHURCH OFFICIAL [Illegible]		100. SIGNATURE OF MINISTER [Illegible]	

BUREAU V. S.

SEP 4 1957

RECEIVED

CERTIFICATE OF DEATH

01247

Reg. Dist. No.

337

1245

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 210 Marshall St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle (OLLIE) Last SHAW WALLER				4. DATE OF DEATH Month January Day 28th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian—H. Salisbury Elementary Public School				10b. KIND OF BUSINESS OR INDUSTRY Laurel Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George B. Waller				14. MOTHER'S MAIDEN NAME Lettie Oliphant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Roxie G. Waller (Wife) Address 210 Marshall St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-6 , 19 57 , to 1-28 , 19 57 , that I last saw the deceased alive on 1-28 , 19 57 , and that death occurred at 11:25AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Medical Center Jan. 29 1957							
ACTUAL SIGNATURE Eugene J. Linberg				M.D. Medical Center			
PHYSICIAN'S NAME (Type) Dr. Eugene J. Linberg				M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE JAN 30 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. DATE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. PLACE OF INTERMENT [Faint text]</p>		<p>16. NAME OF CEMETERY [Faint text]</p>	
<p>17. NAME OF FUNERAL HOME [Faint text]</p>		<p>18. NAME OF NEXT OF KIN [Faint text]</p>	
<p>19. ADDRESS OF NEXT OF KIN [Faint text]</p>		<p>20. CITY AND STATE OF NEXT OF KIN [Faint text]</p>	
<p>21. NAME OF WITNESS [Faint text]</p>		<p>22. ADDRESS OF WITNESS [Faint text]</p>	
<p>23. CITY AND STATE OF WITNESS [Faint text]</p>		<p>24. SIGNATURE OF WITNESS [Faint text]</p>	
<p>25. NAME OF PHYSICIAN [Faint text]</p>		<p>26. ADDRESS OF PHYSICIAN [Faint text]</p>	
<p>27. CITY AND STATE OF PHYSICIAN [Faint text]</p>		<p>28. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>29. NAME OF REGISTRAR [Faint text]</p>		<p>30. ADDRESS OF REGISTRAR [Faint text]</p>	
<p>31. CITY AND STATE OF REGISTRAR [Faint text]</p>		<p>32. SIGNATURE OF REGISTRAR [Faint text]</p>	

RECEIVED
JAN 30 1957
BUREAU V. 5

THIS CERTIFICATE IS NOT VALID UNLESS IT IS SIGNED BY A PHYSICIAN AND A REGISTRAR OF THE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FORWARD IT TO THE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FORWARD IT TO THE REGISTRAR. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FORWARD IT TO THE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FORWARD IT TO THE REGISTRAR.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01248

1246 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>POCOMOKE, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>1902 Rt. 1 Box 54</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Nancy</u> (Middle) <u>Waters</u> (Last) <u>Waters</u>				4. DATE OF DEATH (Month) <u>January</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 12, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HOLLAND</u>				14. MOTHER'S MAIDEN NAME <u>SINCIA WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Alzona Waters - Pocomoke, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
572.1 IMMEDIATE CAUSE (A) <u>Acute intestinal Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial fistula</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterial dissection</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Arterial dissection</u>		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William H. K.</u>				ADDRESS (Street, city, town, state) <u>Salisbury</u>		DATE SIGNED <u> </u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>Unionville</u>		LOCATION (City, town, or county) (State) <u>POCOMOKE, Md.</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS <u> </u>	
DATE <u>1-15-57</u>							

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX ☐ MALE ☐ FEMALE

3. AGE (PRINT OR TYPE)

4. DATE OF BIRTH (PRINT OR TYPE)

5. PLACE OF BIRTH (PRINT OR TYPE)

6. OCCUPATION (PRINT OR TYPE)

7. CAUSE OF DEATH (PRINT OR TYPE)

8. MANNER OF DEATH (PRINT OR TYPE)

9. DATE OF DEATH (PRINT OR TYPE)

10. TIME OF DEATH (PRINT OR TYPE)

11. PLACE OF DEATH (PRINT OR TYPE)

12. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)

13. SIGNATURE OF REGISTRAR (PRINT OR TYPE)

14. SIGNATURE OF WITNESS (PRINT OR TYPE)

15. SIGNATURE OF DECEASED (PRINT OR TYPE)

16. SIGNATURE OF NEXT OF KIN (PRINT OR TYPE)

17. SIGNATURE OF CLERGYMAN (PRINT OR TYPE)

18. SIGNATURE OF CHURCH (PRINT OR TYPE)

19. SIGNATURE OF FUNERAL HOME (PRINT OR TYPE)

20. SIGNATURE OF BURIAL PLACE (PRINT OR TYPE)

21. SIGNATURE OF INTERMENT (PRINT OR TYPE)

22. SIGNATURE OF CREMATION (PRINT OR TYPE)

23. SIGNATURE OF OTHER (PRINT OR TYPE)

24. SIGNATURE OF OTHER (PRINT OR TYPE)

25. SIGNATURE OF OTHER (PRINT OR TYPE)

26. SIGNATURE OF OTHER (PRINT OR TYPE)

27. SIGNATURE OF OTHER (PRINT OR TYPE)

28. SIGNATURE OF OTHER (PRINT OR TYPE)

29. SIGNATURE OF OTHER (PRINT OR TYPE)

3. NAME OF DECEASED (PRINT OR TYPE)

4. SEX ☐ MALE ☐ FEMALE

5. AGE (PRINT OR TYPE)

6. DATE OF BIRTH (PRINT OR TYPE)

7. PLACE OF BIRTH (PRINT OR TYPE)

8. OCCUPATION (PRINT OR TYPE)

9. CAUSE OF DEATH (PRINT OR TYPE)

10. MANNER OF DEATH (PRINT OR TYPE)

11. DATE OF DEATH (PRINT OR TYPE)

12. TIME OF DEATH (PRINT OR TYPE)

13. PLACE OF DEATH (PRINT OR TYPE)

14. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)

15. SIGNATURE OF REGISTRAR (PRINT OR TYPE)

16. SIGNATURE OF WITNESS (PRINT OR TYPE)

17. SIGNATURE OF DECEASED (PRINT OR TYPE)

18. SIGNATURE OF NEXT OF KIN (PRINT OR TYPE)

19. SIGNATURE OF CLERGYMAN (PRINT OR TYPE)

20. SIGNATURE OF CHURCH (PRINT OR TYPE)

21. SIGNATURE OF FUNERAL HOME (PRINT OR TYPE)

22. SIGNATURE OF BURIAL PLACE (PRINT OR TYPE)

23. SIGNATURE OF INTERMENT (PRINT OR TYPE)

24. SIGNATURE OF CREMATION (PRINT OR TYPE)

25. SIGNATURE OF OTHER (PRINT OR TYPE)

26. SIGNATURE OF OTHER (PRINT OR TYPE)

27. SIGNATURE OF OTHER (PRINT OR TYPE)

28. SIGNATURE OF OTHER (PRINT OR TYPE)

29. SIGNATURE OF OTHER (PRINT OR TYPE)

30. SIGNATURE OF OTHER (PRINT OR TYPE)

31. SIGNATURE OF OTHER (PRINT OR TYPE)

RECEIVED

ALL INFORMATION IS HELD IN CONFIDENCE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS INFORMATION AVAILABLE TO THE PUBLIC

ON REQUEST AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

IN A TIMELY AND ACCURATE MANNER

THE DEPARTMENT OF HEALTH IS COMMITTED TO THIS POLICY

AND TO PROVIDE A MEANS FOR THE PUBLIC TO OBTAIN THIS INFORMATION

BUREAU V. 2

JAN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0124332

1247

1. PLACE OF DEATH a. COUNTY Wiconico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS R.D.# 3 (Delmar Rd)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> Unk
3. NAME OF DECEASED (Type or print) First GEORGE Middle RUFUS Last WEST				4. DATE OF DEATH Month January Day 11th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Clinton, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George West				14. MOTHER'S MAIDEN NAME Rebecca McLamb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Clarence C. West (Son) R.D.#3 (Delmar Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/11/57 , 19 57 , to 1/11/57 , 19 57 , that I last saw the deceased alive on 1/11/57 , 19 57 , and that death occurred at 8:20 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred R. Gramse				ADDRESS (Street, city or town, state) S. Division St. (Office) Jan. 12, 1957			
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse				M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Fayetteville Cemetery		22d. LOCATION (City, town, or county) (State) Fayetteville, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.				24a. REC'D BY REGISTRAR JAN 14 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

AN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01253

Reg. Dist. No. 332

1263

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs			c. LENGTH OF STAY in lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wallertown				d. STREET ADDRESS Wallertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Shelley Last Wright				4. DATE OF DEATH Month January Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 7, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57		IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Somerset County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Black				14. MOTHER'S MAIDEN NAME Jane Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Annie D. Wright, Mardela Springs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO (c) Years							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1-8-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Green Acres Cemetery		22d. LOCATION (City, town, or county) (State) Near Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 1-10-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

RECEIVED

JAN 14 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: ☐ MALE ☐ FEMALE
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
8. CAUSE OF DEATH: _____
9. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED
10. SIGNATURE OF EXAMINER: _____
11. DATE OF EXAMINATION: _____

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01250

CERTIFICATE OF DEATH

1248

Reg. Dist. No. 33x

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>9 days</u>		TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE 5</u>			
3. NAME OF DECEASED (Type or Print) <u>Fletcher</u> (First) <u>White</u> (Middle) <u>White</u> (Last)				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>A.H.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>about 1868</u>	9. AGE last birthday <u>about 89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>TWIN LAKES TR. DANIELS - Salisbury, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Nephritis</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Kidney Stone Nephrotic</u>				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 28, 1957</u> to <u>Jan 31, 1957</u> , that I last saw the deceased alive on <u>Jan 31, 1957</u> , and that death occurred at <u>10:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Herbert Lemble</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u> DATE SIGNED <u>4/4/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-3-57</u>		NAME OF CEMETERY OR CREMATORY <u>PARK GREEN ACRES memorial</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Stewart Funeral</u>		ADDRESS <u>Hwy Salisbury, Md</u>	
DATE <u>FEB 5 1957</u>							

CERTIFICATE OF DEATH

1. DATE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF VILLAGE CLERK

26. SIGNATURE OF CITY CLERK

27. SIGNATURE OF STATE CLERK

BUREAU V. 3

FEB 5 1957

RECEIVED

100-100000-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1249

CERTIFICATE OF DEATH

01251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Smith St		d. STREET ADDRESS 702 Smith St	
3. NAME OF DECEASED (Type or print) First LILLIE Middle A. Last WHITE		4. DATE OF DEATH Month JANUARY Day 7th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 2 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kenton, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nathaniel Riggs		14. MOTHER'S MAIDEN NAME Anna Hillyard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. G. Reynolds White (Son)		Address 702 Smith St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 to 1957 , that I last saw the deceased alive on 1/7/57 , and that death occurred at 7:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Gramse M.D.		ADDRESS (Street, city or town, state) S. Division St. (Office) DATE SIGNED Jan. 8, 1957	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JAN 9 1957 24b. REGISTRAR'S SIGNATURE Mary St. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1250 CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS Schumaker Rd	
3. NAME OF DECEASED (Type or print) First MARION Middle SLEMONS Last WILSON		4. DATE OF DEATH Month JANUARY Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR: Months 2 Days 30 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George Wilson	
14. MOTHER'S MAIDEN NAME Lavenia Hastings		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Lula E. Walls (Sister) Address 39 Maple St. Marcus Hook, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Electrolyte imbalance with shock 570.5 DUE TO Intestinal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular accident (c) Chronic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic heart disease			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 Jan. 1956 , to 11 Jan. 1956 , that I last saw the deceased alive on 11 Jan. 1956 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene J. Linberg M.D.		ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Jan. 12 1957	
PHYSICIAN'S NAME (Type) Dr. Eugene J. Linberg M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME ADDRESS SALISBURY, MD.		24a. REC'D BY REGISTRAR JAN 14 1957	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO BE RETAINED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

